

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... PENNSYLVANIA County... SOMERSET

City or town... MEYERSDALE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MR. THOMAS BALDWIN

3. (b) Social Security Number

209-10-6505

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

8. (b) Name of husband or wife... CORA HERNDON

6. (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) FEB 29 1872

8. AGE: Years Months Days It less than one day
74 0 15 hrs. min.

9. Birthplace... ALABAMA
(Town, county, and state)

10. Usual occupation... CELANESE - Retired

11. Industry or business... Corp. of America

12. Name... Harrison Baldwin

13. Birthplace... Columbus, Georgia

14. Maiden name... Elizabeth Bradley

15. Birthplace... Birmingham, Alabama

18. Informant... MEMORIAL HOSPITAL

Address... CUMBERLAND, MD.

17. Burial Date thereof March 17, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Union Cem

Location... Meyersdale, Penna

18. Funeral director... Joseph F. Reich

Address... Meyersdale, Penna.

19. March 14, 1946 Jos. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... MARCH 14 19 46 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7 19 46 to March 14 19 46 and that I last saw him alive on March 13 19 46

Immediate cause of death

Cerebral Apoplexy

DUE TO

DUE TO

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Matthews M.D. M. D. or other

Address 49 Emuel St. Date signed 3-14-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V.S.

Within corporate limits for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

02201

CERTIFICATE OF DEATH

Reg. Dist. No. 4

FILM No. I O 1 APR - 9 1946

1. PLACE OF DEATH:

County Allegany County
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

Six hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 Pear Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr. Richard Marshall Barnard

3. (b) Social Security Number

705-05-8175

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Anna May Taylor

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 25, 1888-1887

8. AGE:

Years

Months

Days

If less than one day

~~5~~

58

7

25

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

B&O R.R.

FATHER

12. Name

William Barnard

13. Birthplace

Maryland

MOTHER

14. Maiden name

Emma Gabler

15. Birthplace

Maryland

16. Informant

Miss Jean Barnard

Address

204 Pear St., Cumberland, Md.

17.

Burial

Date thereof

23 MAR 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Peter's & Paul's Cem.

Cumberland, Md.

Location

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

March 27, 46

J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/21/46

19 to 3/20/46 19

and that I last saw him alive on 3/20/46 19

Immediate cause of death

acute cardiac dilatation

DURATION

Due to

chronic asthma

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Rozum M.D.

M. D. or other

Address

305 West 1st St

Date signed 3/20/46

MARGIN RESERVED FOR BINDING

VS-A15

9-4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02202

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Barton, Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Barton-Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Joseph Silas Beeman

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Daisy Shimer BeemanB. (c) If alive, give age 66 years7. Birth date of deceased (mo., day, yr.) Oct. 26, 18748. AGE: Years 71 Months 4 Days 14 It less than one day _____ hrs. _____ min.9. Birthplace (Near) Lonaconing-Garrett-Md.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Own farm12. Name David Beeman13. Birthplace Garrett-Ct. Md.14. Maiden name Elizabeth Crowe.15. Birthplace New Germany, Md.16. Informant Walter BeemanAddress Barton, Md.17. Burial Burial Date thereof Mar. 13, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Allegany Cem.Location Frostburg, Md.18. Funeral director Ellsworth S. BoalAddress Westernport, Md.19. Mar. 13, 46 Registrar J. J. Baker

(Date rec'd by registrar)

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 10th, 19 46, at 4.30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19_____, to _____ 19_____,

and that I last saw him _____ alive on _____ 19_____,

Immediate cause of death _____

Chronic Myocarditis DURATION 4 yrs.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations. _____

Date of op. _____

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Russ H. Brown, M.D. M. D. or other _____Address Cumberland, Maryland Date signed 3-10-46

Deputy Medical Examiner - Allegany Co.

RECEIVED
MAR 14 1946
BUREAU T.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

02203

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Allegany
 City or town Flintstone, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 75 years
 Hospital, institution, or street address where death occurred:
Flintstone, Md.
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Dennis Benneff

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Married

6. (b) Name of husband or wife Jessie Agnes "Elbin" Bennett7. Birth date of deceased (mo., day, yr.) January 17, 18718. AGE: Years Months Days If less than one day
75 2 10 hrs. min.9. Birthplace Bedford County, Penna.
(Town, county, and state)10. Usual occupation Retired Store Keeper11. Industry or business General Store12. Name George S. Bennett13. Birthplace Bedford County, Penna.14. Maiden name Sarah Ines15. Birthplace Bedford County, Penna.16. Informant W. Clyde BennettAddress Cumberland, Maryland.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof March 30 1946
(month) (day) (year)Cemetery or crematory Willcrest CemeteryLocation Cumberland, Maryland16. Funeral director John J. HaferAddress Cumberland, Maryland.19. March 29, 46 Dennis D. Bender
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 March 1946 at 7:15 p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1946 to March 27 1946and that I last saw him alive on March 20 1946Immediate cause of death Pneumonia DURATION 7 days

? ?

Due to ?

Due to ?

Due to ?

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations. _____ Date of op. _____

Autopsy results. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE W. P. Hodges, M.D.Address Cumberland, Md. M. D. or other _____Date signed 3/28/46

RECEIVED
APR 1 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(526)

CERTIFICATE OF DEATH

Reg. Dist. No. 2204

1. PLACE OF DEATH:

County AlleganyCity or town Westernport-Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Westernport-Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ulysses Marcellus Bernard.

3. (b) Social Security Number

217-09-6440

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Anne Bernard

7. Birth date of deceased (mo., day, yr.)

July 6, 1879

6. (c) If alive, give age _____ years

8. AGE:

66 Years8 Months12 Days

If less than one day

_____ hrs. _____ min.

9. Birthplace

Moscow-Allegany-Md.

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

Rail-road

FATHER

12. Name

William B. Bernard.

13. Birthplace

Md.

MOTHER

14. Maiden name

Mary Smiley

15. Birthplace

Va.

16. Informant

Mr. William Bernard

Address

Westernport, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Mar. 21, 1946
(month) (day) (year)

Cemetery or crematory

Philos Cem.

Location

Westernport, Md.

18. Funeral director

Ellsworth S. Roal

Address

Westernport, Md.

19. Registrar

(Date rec'd by registrar)

18

Registrar

MEDICAL CERTIFICATION

2B. DATE OF DEATH Mar. 18 19 46 at 11.20 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 18 19 46 to Mar 18 19 46and that I last saw him alive on Mar 18 19 46

Immediate cause of death

Hemorrhage of Urinary Bladder and Intestines
Due to Carcinoma of Bladder and Intestines

DURATION

One DayUnknownDue to Primary site, and duration: Unknown. Referred.
Diagnosis was based upon one examination of patient.Other conditions a few hours before death

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. _____

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE

Paul A. Wilson M.D.

M. D. or other

Address

Piedmont, W. Va.Date signed Mar 20, 1946

RECEIVED

CENTRE DE RECHERCHES

DE RECHERCHES

1900-1901

RECEIVED

MAR 23 1901

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

02205

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Allegany
 City or town Town Creek near Flintstone
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Allegany
 City or town Town Creek near Flintstone
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Virgil Royce Bolyard

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male white Child

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1945

8. AGE: Years 1 Months 1 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Town Creek, Allegany Co, Ind
(Town, county, and state)10. Usual occupation Child

11. Industry or business _____

12. Name Homer Bolyard13. Birthplace Barber Co. W. Va.14. Maiden name Andrea Mc Donald15. Birthplace Grafton W. Va.16. Informant Homer BolyardAddress Route 1 Oldtown Ind.17. Burial Date thereof Mar 24 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Brethren CemeteryLocation near Flintstone Ind.18. Funeral director John J. HaferAddress Chamberland Ind.19. March 22 46 Thos B. Bender
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 22 19 46 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 17 19 46 to Mar. 22 19 46and that I last saw him alive on Mar. 19 19 46Immediate cause of death Pneumonia

DURATION

5 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. A. Watson, M.D.

M. D. or other

Address Little Orleans, Md. Date signed 3/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 25 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-6

02206

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 Yrs

Hospital, institution, or street address where death occurred:

Kolbergs Hill

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. Kolbergs Hill

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

David Bothwell

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Grace Bothwell6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) June 25, 1869

8. AGE:

76

Years

8

Months

Days

11

If less than one day

hrs. min.

9. Birthplace Scotland

(Town, county and state)

10. Usual occupation Signal Tower Operator11. Industry or business Rail-Road.12. Name William Bothwell13. Birthplace Scotland14. Maiden name Marjorie Archibald15. Birthplace Scotland16. Informant Mrs. David BothwellAddress Westernport, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Mar. 9, 46

(month) (day) (year)

Cemetery or crematory Philos Cem.Location Westernport, Md.18. Funeral director Ellsworth S. RoalAddress Westernport, Md.19. Mar. 9

(Date rec'd by registrar)

19. H. G. Kraynhaber MD

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6 1946 at 1.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1945 1945 to Mar 6 1946and that I last saw him alive on Mar 5th 1946

Immediate cause of death

Canceroma

DURATION

7 monthsDue to Prostate gland

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE MD

M. D. or other

Address Westernport, Md.Date signed 3/6/46

RECEIVED

MAR 11 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 38-2

02207

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 61 years.
 Hospital, institution, or street address where death occurred:
507 Oldtown Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 507 Oldtown Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Joseph H Brinker

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Rosa E Kessler7. Birth date of deceased (mo., day, yr.) 18 October 1884 6. (c) If alive, give age 3-10-46 years8. AGE: Years 61 Months 5 Days 3 If less than one day hrs. min.9. Birthplace Cumberland, Allegany Co., Md.
(Town, county, and state)10. Usual occupation Farm supplies
own business.

11. Industry or business

12. Name Mathias Brinker13. Birthplace Maryland14. Maiden name Louise Ruppenkamp15. Birthplace Maryland16. Informant George A. Brinker
Address 507 Oldtown Road, Cumberland, Md.17. Burial St. Peter's & Paul's Cemetery
(Burial, cremation, or removal. Which?) Cumberland, Maryland.
Date thereof 23 MAR 1946
(month) (day) (year)
Cemetery or crematory Cumberland, Maryland.
Location18. Funeral director Louis Stein, Inc.
Address Cumberland, Maryland.19. March 22, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 19 46 at 12:30 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-10-46 to 3-20-46 and that I last saw him live on 19 46

Immediate cause of death

Chickenpox

DURATION

19 days

Due to

Due to

Other conditions

Hypostatic Pneumonia48 hrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. J. Johnson, M.D.
Cumberland, Md. Date signed 3-21-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU 78

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

02208

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 127 Columbia St.
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME
Miss Rebecca Ann Bucy

3.(b) Social Security Number
None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife _____

B.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 26, 1878

8. AGE: Years 68 Months 0 Days 0 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name William Bucy

13. Birthplace Allegany Co., Md

14. Maiden name Stacia Shaw

15. Birthplace Allegany Co., Md

16. Informant John F. Hefner

Address Cumberland, Md.

17. Burial Date thereof March 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John F. Hefner

Address Cumberland, Md.

19. March 28, 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 3/26/46 19____ at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/21 1946 to 3/26 1946

and that I last saw him alive on 3/26/46 19____

Immediate cause of death Cerebral aneurysm

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John F. Hefner M.D.

Address 305 Decatur St. Date signed 3/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 3 1946
BUREAU V.B.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... Allegany

City or town..... Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Allegany

City or town..... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No..... 313 Greene Street
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (a) FULL NAME

Mrs. Margaret Burch

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife..... Martin L. Burch

6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) March 30, 1905

8. AGE: Years Months Days it less than one day
40 11 9 hrs. min.9. Birthplace..... Maryland, Cumberland, Alleg. Co.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

12. Name..... John Sticher

13. Birthplace..... Maryland

14. Maiden name..... Helen Baillie

15. Birthplace..... Maryland

16. Informant..... Memorial Hospital

Address..... Cumberland, Maryland

17. Burial Date thereof..... Mar 13 '46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cem

Location..... Cumberland

18. Funeral director..... Louis Stein Inc

Address..... Cumberland

19. March 13, 1946 J. P. Kaubku, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 11 1946 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5-11-1946 3:11 PM

and that I last saw him live on 3-11-1946

Immediate cause of death.....

Chronic Glomerulonephritis

Due to.....

Diabetes (uremia)

Due to.....

Hypertension

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

None

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....

Address..... Date signed.....

RECEIVED

MAR 20 1946

BUREAU U.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 yrs

Hospital, institution, or street address where death occurred:

Allegheny County InfirmaryHow long in hospital or institution? 5 yrs

3. (a) FULL NAME

Robert Walter Cameron

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 16, 1877

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

68712hrs.min.

9. Birthplace

Lonaconing, Allegany Co. Md.
(Town, county, and state)

10. Usual occupation

Coal Miner retired

11. Industry or business

Darrows Coal Co.

12. Name

Archibell Cameron

13. Birthplace

Scotland

14. Maiden name

Jane McLeckie

15. Birthplace

Scotland

16. Informant

William Cameron

Address

Lonaconing, Md.

17. (Burial, cremation, or removal. Which?)

BurialDate thereof March 30, 1946
(month) (day) (year)

Cemetery or crematory

Oak Hill Cem

Location

Lonaconing, Md.

18. Funeral director

M. Eichhorn

Address

Lonaconing, Md.19. March 29, 1946
(Date rec'd by registrar)J.P. Franklin, Md.
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-28-46 at 2:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-7-46 to 3-28-46
and that I last saw him alive on 3-27-46

Immediate cause of death

Cerebral
Hemorrhage

DURATION

5 yrs.

Due to

Chronic Hypertension

Due to

Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NoneDate of op. None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

W.F. Williams

M. D.

Address

CumberlandDate signed 3-28-46

RECEIVED

APR 3 1946

BUREAU V.E.

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02211

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural, Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred:

Frantztown, Route 3, Cumberland, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural, Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Frantztown, Route 3,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ALBERT EDWARD CHARLES

3. (b) Social Security Number

705-09-9968

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Mrs. Effie Simons Charles

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8, 1891

8. AGE: Years Months Days If less than one day
54 5 8 hrs. min.

9. Birthplace Ridgeley, Mineral, West Virginia
(Town, county, and state)

10. Usual occupation Electrician

11. Industry or business B. & O. R. R.

12. Name F. Henry Charles

13. Birthplace Frantzville, Maryland

14. Maiden name Bertha Jenkins

15. Birthplace Hancock, Maryland

16. Informant Mrs. Effie Charles

Address Route 3, Cumberland, Maryland

17. Burial Date thereof March 19, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetery

Location Cumberland, Maryland

18. Funeral director William H. Kight

Address Cumberland, Maryland

19. March 19, 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH March 16, 19 46 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 15, 1946 to May 16, 1946
and that I last saw him alive on May 16, 1946

Immediate cause of death Coronary Thrombosis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.P. Franklin, M.D. M. D. or other
West. Bldg. Cumberland Date signed 3/17/46
Address

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 22 1946
JOURNAL A. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH:

County AlleganyCity or town Midland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Midland
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Joseph J. Corrigan

3. (b) Social Security Number

218-09-72964. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Ruthie Sulser6.(c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) July 31, 18678. AGE: Years 78 Months 7 Days 7 If less than one day

hrs. min.

9. Birthplace Chicago, Ill.
(Town, county, and state)10. Usual occupation Coal Miner11. Industry or business Gorges Creek Big Vein Coal Co.12. Name Patrick Corrigan13. Birthplace Ireland14. Maiden name Unknown15. Birthplace Unknown16. Informant David CorriganAddress Midland, Md.17. Burial Date thereof Mar. 21, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Belvedere CemeteryLocation Midland, Md.18. Funeral director M. EichhornAddress Gomac Spring, Md.19. Mar. 21, 1946 Dr. E. O. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 1946 at 11:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1946 to March 8, 1946and that I last saw him alive on March 8, 1946Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herring M. Hodelson M.D.Address Gomac Spring, Md. Date signed Mar. 21, 1946

RECEIVED

MAR 15 1946

BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State West Virginia County Mineral
City or town Ridgeley
(If outside city or town limits, write RURAL and give nearest town)
Street No. Potomac St.
(If rural, give LOCATION)
2(a) If veteran, name war ✓

3. (a) FULL NAME

Mr. Walter Cunningham

3. (b) Social Security Number

232-20-3348

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mildred Wamsley

6. (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) April 14, 1919

8. AGE: Years 26 Months 10 Days 22 If less than one day hrs. min.

9. Birthplace West Virginia, Hendricks, Tucker Co.
(Town, county, and state)

10. Usual occupation Fireman

11. Industry or business W. Maryland Railroad

12. Name A. L. Cunningham

13. Birthplace West Virginia, Horton

14. Maiden name Bertha Phillips

15. Birthplace West Virginia, Hendricks

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Removal Date thereof Mar 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fausler Cemetery

Location Hendricks, W. Va.

18. Funeral director John J. Hager

Address Cumberland, Md.

19. March 7, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 1946, at 7:24 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 3, 1946, to Mar. 6, 1946

and that I last saw him alive on Mar. 5, 1946

Immediate cause of death Diabetic Coma

Due to Diabetic Mellitus & Nephritis

Other conditions Heart attack

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Jones, M.D. M. D. or other

Address Medical Bldg Date signed 3-7-46

MARGIN RESERVED FOR BINDING

VS A15 9-45 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1310

CERTIFICATE OF DEATH

02214

Reg. Dist. No. 14

1. PLACE OF DEATH: *Allegheny*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *55 years*
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants, give residence of mother)
 State *Maryland* County *Allegheny*
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME *Caroline L. Daniels*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*
 6. (b) Name of husband or wife *John J. Daniels*
 7. Birth date of deceased (mo., day, yr.) *March 24, 1863* 6. (c) If alive, give age..... years

8. AGE: Years *82* Months *11* Days *24* If less than one day..... hrs. min.

9. Birthplace *Keiper, W. Va.*
 (Town, county, and state)

10. Usual occupation *Housewife*

11. Industry or business *Dennis Daniels*

12. Name *Dennis Daniels*

13. Birthplace *Keiper, W. Va.*

14. Maiden name *Margaret Fleet*

15. Birthplace *Keiper, W. Va.*

18. Informant *Mary B. Lowery*

Address *Ellensburg, Md.*

17. *Burial* Date thereof *Mar. 20 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Rose Hill*

Location *Cumberland*

18. Funeral director *Harvey H. Lepler*

Address *Hyndman, Pa.*

19. *March 19 46* J. P. Lloyd Wolf
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *3/18* 19 *46*, at *5 A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *3/1* 19 *46*, to *3/18* 19 *46*
 and that I last saw him alive on *3. 18. 46*

Immediate cause of death *Chronic Arterio* DURATION

Sclerotic Cardio Renal *15 yrs.*

Due to *Disease*

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J. A. Lepper MD* M. D. or other

Address *Hyndman, Pa.* Date signed *3/18/46*

RECEIVED

MAR 30 1946

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland, (RURAL)
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. #2, Williams Road
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mr. Harvey Davis

3. (b) Social Security Number

213-18-27174. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mrs. Eva Davis

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 29th, 18898. AGE: Years 56 Months 2 Days 15 If less than one day XIX hrs. _____ min.9. Birthplace Allegany Co., Maryland
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name William Ellsworth Davis13. Birthplace MarylandMOTHER 14. Maiden name Ella Catherine Valentine15. Birthplace Maryland16. Informant Eva Ellen DavisAddress Rt. #2, Williams Rd., Cumb., Md.17. Burial Date thereof 19 MAR 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Herman CemeteryCumberland, Md.

Location

18. Funeral director Louis Stein, Inc.Address Cumberland, Md.19. March 19, 1946 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/16 1946 at 7:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-13-46 to 3-16-46and that I last saw him alive on 19Immediate cause of death Right side of lung DURATION 3 daysright side of lungright side of lung

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-6-46Where did injury occur? Cumberland, Allegany (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Removal by ambulance Injured at work? Work23. SIGNATURE J. P. Franklin, M.D. M. D. or otherAddress Cumberland, Md. signed 3-16-46

RECEIVED

RECEIVED

RECEIVED

MAR 26 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 13 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-2

02217

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 years
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 16. East Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Upton Edward Dawson

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Marietta Whipp Dawson6. (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.)

December 19, 1865

8. AGE:

Years

Months

Days

If less than one day

8032

hrs.

min.

9. Birthplace Rawlings, Allegany, Maryland
(Town, county, and state)

10. Usual occupation

Manager11. Industry or business Cumhd Improvement Ware House

FATHER

12. Name Eli W. Dawson13. Birthplace Rawlings, Maryland

MOTHER

14. Maiden name Lucy Jacobs15. Birthplace Lonaconing, Maryland16. Informant Mrs. Upton E. DawsonAddress 16 East Street, Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?)

Date thereof 3/23/46
(month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Md18. Funeral director William H. KightAddress Cumberland, Md.19. March 23, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1946 at 12- A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Tueh 16, 1946 to Tueh 21, 1946
and that I last saw him alive on Tueh 21, 1946

Immediate cause of death

DURATION

Parasym. Agitans

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

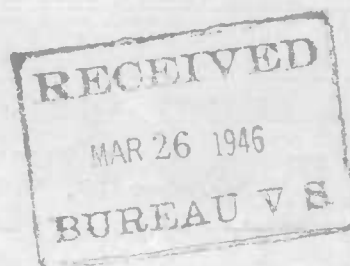
M. D. or other

Address 49 Green StDate signed 3-21-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

02218

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... AlleghenyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution or street address where death occurred:

Sylvan RetreatHow long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleghenyCity or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 214 Harrison St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mrs. Nellie E. Dayton

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Charles E. Dayton

7. Birth date of deceased (mo., day, yr.)

Aug 16 1879

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

66 7 7 hrs. min.

9. Birthplace

Keyser W. Va.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

MOTHER FATHER

12. Name

Edgar H. Davis

13. Birthplace

Va.

14. Maiden name

Lucy Crowell

15. Birthplace

Va.

16. Informant

Mr. H. S. Caldwell

Address

Keyser W. Va.

17. Burial

(Burial, cremation, or removal. Which?)

CremationDate thereof Mar 25 46
(month) (day) (year)

Cemetery or crematory

Queen's Pt. Cem.

Location

Keyser W. Va.

18. Funeral director

Home Stein Inc.

Address

Cumberland19. March 25, 46
(Date rec'd by registrar)J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

3-23-46 at 1:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 8 1946 to 3-23-46and that I last saw him alive on March 20, 1946

Immediate cause of death

CerebralhemorrhageDue to Generalizedarterio-sclerosisDue to P.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. WilliamsCumberland M. D. or otherAddress 3/24/46 Date signed

RECEIVED

APR 3 1946

BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Bowman's Addition

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Baby Girl Diehl

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/1/468. AGE: Years Months Days If less than one day
9 hrs. min.9. Birthplace Cumberland, Allegany, Maryland
(Town, county, and state)10. Usual occupation Infant

11. Industry or business

12. Name Lloyd S. Diehl13. Birthplace Manna Choice, Penna.14. Maiden name Gay See15. Birthplace Mathias, W. Va.18. Informant Lloyd S. DiehlAddress Bowmans Addition, Cumberland, Md17. Burial Date thereof Mar. 13, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mathias Cem.Location Mathias, W. Va.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. March 17, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/10 19 46 at 4:40 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1946 to March 10, 1946
and that I last saw h. ER alive on March 9 19 46Immediate cause of death Malnutrition DURATION 10 daysDue to Constriction at cardiac end of stomach 10 days

Due to

Other conditions Unable to take nourishment
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results as above 3/11/46 Date of op.

PHYSICIAN: Please order time the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. V. Deming M.D. M. D. or otherAddress 125 Bedford St Date signed 3-11/46

RECEIVED

MAR 20 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 308 B. Front St. 2yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Westernport
(If outside city or town limits, write RURAL and give nearest town)Street No. 308.B. Front St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Shirley Elizabeth Dixon

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1944

8. AGE:

Years

Months

Days

If less than one day

2127

Hrs.

min.

9. Birthplace Westernport-Allegany-Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Floyd Dixon13. Birthplace Hampshire, W.Va.14. Maiden name Madeline Barb15. Birthplace Elkins, W.Va.16. Informant Floyd DixonAddress Westernport, Md.17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Mar. 21, 46
(month) (day) (year)Cemetery or crematory Philos Cem.Location Westernport, Md.18. Funeral director Ellsworth S. BoalAddress Westernport, Md.19. Mar 21 46 Allegany
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 20, 1946 19 46 at 6:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 19 19 46 to Mar. 20 19 46and that I last saw h.r. alive on Mar. 20 19 46Immediate cause of death PurpuraHaemorrhagica

DURATION

2 Days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson, M.D.

M. D. or other

Address Piedmont, W. Va. Date signed Mar. 20, 1946

RECEIVED

MAR 23 1946

BUREAU V &

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CRESAPTOWN
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

KATHERINE SKELLEY DOUTHITT

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Leon Douthitt

7. Birth date of deceased (mo., day, yr.) Aug 15 1917

6. (c) If alive, give age _____ years

8. AGE: Years 28 Months 7 Days 10
It less than one day _____ hrs. _____ min.

9. Birthplace Cresaptown Ind.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

12. Name John Skelley

13. Birthplace Ind

14. Maiden name Charlotte C. Belkott

15. Birthplace Ind

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial, cremation, or removal, Which? Burial Date thereof Mar 28 46
(month) (day) (year)

Cemetery or crematory St Ambrose Cem

Location of Cresaptown Ind

18. Funeral director Louis Stein Inc

Address Cumberland

19. March 28, 46 (Date rec'd by registrar) I. P. Haublin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 25, 1946 7:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAR. 20, 46 to MAR. 25, 46

and that I last saw her alive on March 25, 1946

Immediate cause of death Cerebro-Spinal Meningitis

DURATION

Due to No organisms were found. Cereb.

Due to Tuberculous meningitis. Duration 1 mine days

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE R. A. Pleasheers M.D. or other

Address 49 Greene St Date signed 3-27-46

MARGIN RESERVED FOR BINDING

VS A15 9-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Matthews

RECEIVED

APR 3 1946

BUREAU VS

Matthews

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND? MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 16 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County GRANT

City or town PETERSBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

GEORGE FEASTER

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3, 1881

8. AGE: Years Months Days If less than one day
64 4 25 hrs. min.

9. City Grant Co., WEST VIRGINIA
(Town, county, and state)

10. Usual occupation LABORER - FARM

11. Industry or business

12. Name CRITTY FEASTER

13. Birthplace West Virginia

14. Maiden Name KEPLINGER

15. Birthplace West Virginia

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND? MD.

17. Burial Date thereon March 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Lebanon Ceme

Location Near Petersburg, W. Va.

18. Funeral director Earl Bush

Address Petersburg, W. Va.

19. March 30, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH MARCH 28 19 46 at 11:25 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-12- 19 46 to 3-28- 19 46
and that I last saw him alive on 3-28- 19 46

Immediate cause of death

Chronic nephritis
Benign hypertrophy, prostate

Due to

Due to

Other conditions Insanity

(Include pregnancy within 3 months of death)

Major findings of operation

Vasectomy Date of op. 3-25

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)?

Means of injury

Injured at work?

23. SIGNATURE Howard L. Tolson, M.D.

Address Cumberland, Md. Date signed 3-30-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1912

CERTIFICATE OF DEATH

02222

Reg. Dist. No. 14

1. PLACE OF DEATH:

County AlleganyCity or town Corriganville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Corriganville

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

David Clarence Fleegle

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Laura Shatzer Fleegle6. (c) If alive, give age 71 years7. Birth date of deceased (mo., day, yr.) Dec. 19, 1871

8. AGE: Years Months Days If less than one day

74218

hrs. min.

9. Birthplace Ellerslie, Md.

(Town, county, and state)

10. Usual occupation Janitor

11. Industry or business

12. Name Valentine E. Fleegle13. Birthplace Germany14. Maiden name Mary C. Burkett15. Birthplace Ellerslie, Md.16. Informant Mrs. Pearl CochranAddress Corriganville, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof March 10, 1946

(month) (day) (year)

Cemetery or crematory xxxxx HillcrestLocation Cumberland, Md.18. Funeral director Harvey H. ZeiglerAddress Hyndman, Pa.19. March 9, 46 Registrar J. Lloyd Wall

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 19 46, at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 45 to March 6 19 46 and that I last saw him alive on March 6 19 46Immediate cause of death Mycocarditis.

DURATION

Due to _____

Due to _____

Other conditions Bronchitis as chronicChronic Nephritis -

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE William E. Moseley M. D. or otherAddress 174 Savage Rd Date signed 3-9-46

RECEIVED

MAR 30 1946

BUREAU V E

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 88 years

Hospital, institution, or street address where death occurred:

Allegheny County Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 432 1/2 Center St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Margaret Sabina Foreman

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife James Foreman

7. Birth date of deceased (mo., day, yr.) December 29, 1857 8. (c) If alive, give age 88 years

8. AGE: Years 88 Months 2 Days 8 If less than one day hrs. min.

9. Birthplace Cumberland, Allegheny, MD
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Snyder

13. Birthplace Germany

14. Maiden name ?

15. Birthplace

16. Informant Mrs Elwood Foreman

Address 15 1/2 Lee St Cumb. Md.

17. Burial St Peters & Pauls Cemetery Date thereof Mar 11, 1946
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Cumberland Md

Location John J. Hofer

18. Funeral director John J. Hofer

Address Cumberland Md.

19. March 9, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 46 at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5:40 19 46 to 3:10 19 46
and that I last saw her alive on 3:6 19 46

Immediate cause of death Infirmities of age

Due to

Other conditions Generalized Arteriosclerosis
(Include pregnancy within 4 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. Cumberland 3-8-46
Address Cumberland Date signed 3-8-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1946

BURBANK, CA

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

02224

CERTIFICATE OF DEATH

Reg. Dist. No. 9

FILM No. 101 MAR 13 1946

1. PLACE OF DEATH:

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Spencer Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Eastport, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Joseph Galloray

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Caucasian

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Estelle Graham

7. Birth date of deceased (mo., day, yr.)

Mar. 12 - 1871

6. (c) If alive, give age _____ years

8. AGE:

Years 74

Months

7

Days

1

Days

20

If less than one day

hrs. _____

min. _____

9. Birthplace

Oakland, Md.
(Town, county, and state)

10. Usual occupation

Manager

11. Industry or business

Coal mines

FATHER

12. Name

John Galloray

13. Birthplace

Don't know

MOTHER

14. Maiden name

Don't know

15. Birthplace

Don't know

16. Informant

Mrs. Helen Davis

Address

79 Linden St. Frostburg, Md.

17. Burial

Burial

Date thereof

3-5-1946
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

Joseph Rafter

Address

Frostburg, Md.

19. (Date rec'd by registrar)

3-4-46

Mrs. Nancy H. Roe

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 46, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 28 19 46 to March 2 19 46

and that I last saw him alive on March 2 19 46

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 days

Due to

arterio-sclerosis

Due to

Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H.C. Diehl, M.D.

M. D. or other

Address

Frostburg, Md.

Date signed 3/4/46

RECEIVED

MAR 5 1946

BUREAU V.O.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits
Evidence for change of year
of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 774

FILM No. I O 1 MAR 28 1946

CERTIFICATE OF DEATH

02225

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town BARTON
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

CLARENCE L. GREEN

3. (b) Social Security Number

213-01-8865

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE

WHITE

MARRIED

6. (b) Name of husband or wife ALICE WARNICK

6. (c) If alive, give age 38 years

7. Birth data of deceased (mo., day, yr.) APRIL 29, 1898 1902

8. AGE: Years 43 Months 10 Days 13 If less than one day
..... hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation MINER

11. Industry or business Roanoke Coal Co.

12. Name FRANK GREEN

13. Birthplace MARYLAND

14. Maiden name ELLEN CLARK

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date there Mar 15 1946
(Burial, cremation, or removed. Which?) (month) (day) (year)

Cemetery or crematory Laurel Hill Cem

Location Mascot, Md.

18. Funeral director M. Eichhorn

Address Frederick, Md.

19. March 15, 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 12, 1946 1:10 PM

21. I CERTIFY that death occurred on the data above stated; that I attended deceased from

Mar. 7, 1946, to Mar. 12, 1946

and that I last saw him alive on Mar. 12, 1946

Immediate cause of death Shock following DURATION 5 days

fracture of femur

Due to gunshot

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accidental Date of 3-7-46

Where did injury occur? Swanton Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) mine

Means of injury Coal fall in mine Injured at work? yes

23. SIGNATURE J. M. Wilson M.D. or other

Address Cumberland Md Date signed 3-14-46

RECEIVED

MAR 20 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

02226

Reg. Dist. No. 8

1. PLACE OF DEATH: Allegany
 County.....
 City or town.....Harpersville, near Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....11 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Allegany
 City or town.....Harpersville, near Lonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Annie Coleman Hanlin

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, or divorced.....Married

6.(b) Name of husband or wife.....Charles Hanlin

7. Birth date of deceased (mo., day, yr.).....January 6, 1894 6.(c) If alive, give age.....43 years

8. AGE: Years.....52 Months.....1 Days.....29 If less than one day..... hrs. min.

9. Birthplace.....Gilmore, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation.....Housewife

11. Industry or business.....Own home

12. Name.....Benjamin Coleman

13. Birthplace.....Drum Mt. near Lonaconing

14. Maiden name.....Annanda Poland

15. Birthplace.....Farm. near Barton

16. Informant.....Charles Hanlin

Address.....Lonaconing, Md.

17. Burial.....Burial Date thereof.....Mar. 8, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Laurel Hill Cemetery

Location.....Morcom, Md.

18. Funeral director.....M. Eichhorn

Address.....Lonaconing, Md.

19. Mar 8 1946 Dr. R. D. O'Neil
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 5 1946 at.....1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....Dec 20 1945 to.....Mar 5 1946
 and that I last saw.....her alive on.....March 6 1946

Immediate cause of death.....Carcinoma of breast

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Henry M. Hodgson M. D. or other

Address.....Lonaconing, Md. Date signed.....Mar 7 '46

RECEIVED

MAR 9 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

02228

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

Allegany Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 507 Decatur St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Edward Harvey Hast

3.(b) Social Security Number

214-05-5062

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Blanche Jay

7. Birth date of

deceased (mo., day, yr.)

May 27, 1875

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

70918

hrs.

min.

9. Birthplace

Chaneysville Bedford Co Pa
(Town, county, and state)

10. Usual occupation

Concrete Work (Retired)

11. Industry or business

General Concrete Work

FATHER

12. Name

John H. Hast

13. Birthplace

Germany

MOTHER

14. Maiden name

Margaret Seigler

15. Birthplace

Germany

16. Informant

E. Carl Hast

Address

507 Decatur St - Camb. Ind

17.

(Burial, cremation, or removal. Which?)

Date thereof

March 18, 1946
(month) (day) (year)

Cemetery or crematory

Greenmount Cemetery

Location

Cumberland, Maryland

18. Funeral director

John J. Hast

Address

Cumberland, Maryland

19.

(Date rec'd by registrar)

March 18, 1946

Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 15th., 1946 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him... alive on 19...

Immediate cause of death

Fractured skull; fractured pelvis;
fractured ribs.

DURATION

19 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no operation

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-24-46Where did injury occur? Cumberland, Allegany, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) R.R. CrossingMeans of injury struck by train Injured at work? no

23. SIGNATURE

James H. Brown, M.D.

M. D. or other

Address Cumberland, Maryland Date signed 3-16-46

Deputy Medical Examiner - Allegany Co

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU V S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

02229

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Thomas Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Mr. John Heier

3. (b) Social Security Number
220-07-6780

4. Sex Male
5. Color or race White
6. (a) Single, married, widowed, or divorced Divorced

6. (b) Name of husband or wife Mary Carey Heier
6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) October 17, 1877

8. AGE: Years 68 Months 5 Days 3 If less than one day
hrs. min.

9. Birthplace Maryland, Cumberland
(Town, county, and state)

10. Usual occupation Retired Stationary Engineer

11. Industry or business Empire Ice Co.

12. Name Deceased John Heier

13. Birthplace Cumberland, Md

14. Maiden name Deceased Elizabeth Betzold

15. Birthplace Cumberland, Md.

16. Informant Carrie Knapp

Address Cumberland, Md.

17. Burial Date thereof March 22, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Lukes Lutheran Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hoffer

Address Cumberland, Md.

19. March 22, 46 Registrar J.P. Marklin, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 46 at 6:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 19 46 to March 20 19 46
and that I last saw him alive on March 19 19 46

Immediate cause of death Labor Pneumonia DURATION 3 weeks
Wernicke months
Hypertrophic Carditis years

Due to Hypertensive C.V. Disease

Due to Heart

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Blair M. Schreiber M. D. or other

Address 41 Duval St Date signed March 22, 1946

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

02230

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:

County AlleganyCity or town Refer
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 yrsHospital, institution, or street address where death occurred:
1411 Hwy

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County AlleganyCity or town Refer
(If outside city or town limits, write RURAL and give nearest town)Street No. 1411 Hwy
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Malvina Louisa Heinrich

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Philip Heinrich

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 1 18798. AGE: Years 66 Months 4 Days 27 If less than one day _____ hrs. _____ min.9. Birthplace Ind
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at Home12. Name Charles Hesser13. Birthplace Ind14. Maiden name Mary Beaser15. Birthplace Va.16. Informant Miss Lillian HesserAddress Refer Ind.17. Burial Date thereof March 31 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory East Olive Cem.Location Pine Hill, Ind.18. Funeral director Louis Stein IncAddress Cumberland19. March 30 19. 46 Mrs E. A. Monholtz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28th. 19. 46 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19. _____ to _____ 19. _____

and that I last saw h. _____ alive on _____ 19. _____

Immediate cause of death _____

Coronary Occlusion

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Primer H. Benson, M.D. M. D. or otherCumberland, Maryland Date signed 3-28-46

Address _____ Deputy Medical Examiner - Allegany Co.

RECEIVED

APR 5 1946

BUREAU OF

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution or street address where death occurred

317 Pulaski St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 317 Pulaski
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Ambrose Holzen

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 4, 1884

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

63

hrs.

min.

9. Birthplace

Cumberland Md
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

John Holzen

13. Birthplace

Md

14. Maiden name

Katharine Paulas

15. Birthplace

Md

18. Informant

Agnes Holzen

Address

Cumberland Md

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

Mar 26 1946
(month) (day) (year)

Cemetery or crematory

St Peter & Paul

Location

Fayette St Cumberland Md

18. Funeral director

Garris & Son Inc

Address

Cumberland Md

19. (Date rec'd by registrar)

March 25, 1946J.P. Franklin M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 2419 46 at 8:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1019 46

to

March 2419 46

and that I last saw him alive on

March 2319 46

Immediate cause of death

Cerebral Constriction

DURATION

Very

Due to

Cerebral Constriction29m

Due to

Organic Heart Disease29m

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John A. Holzen

M. D. or other

Address

Cumberland Md

Date signed

4/3

RECEIVED

RECEIVED

RECEIVED

APR 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits
Dr. Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186-2

02232

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 44 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 608 Montgomery Avenue
(If rural, give LOCATION)

2.(u) If veteran, name war

3. (a) FULL NAME

Mrs. Nettie Hurdle

3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
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6. (b) Name of husband or wife Edre Hurdle

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7 1861

8. AGE: Years <u>84</u>	Months <u>7</u>	Days <u>24</u>	If less than one day hrs. min.
----------------------------	--------------------	-------------------	--

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Small

13. Birthplace Maryland

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof Apr. 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Wood Cem.

Location Richmond, Va.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. April 2, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1946 4:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15, 1946 to Mar 31, 1946

and that I last saw him alive on March 31, 1946

Immediate cause of death

Ch. myocarditis DURATION ?

Due to Ch. hypertitis ?

Due to Fractured femur 44 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-15-46

Where did injury occur? Cumberland, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) County home

Means of injury fallen from roof Injured at work? no

23. SIGNATURE J. M. Wilson M. D. or other

Address Cumberland, Md. Date signed 4-1-46

RECEIVED

APR 3 1946

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 yearsHospital, institution, or street address where death occurred:
628 Frederick St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 628 Frederick St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Theodore Sanford James

3.(b) Social Security Number

217-10-4416

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Angela Gross6.(c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) October 10, 18878. AGE: Years 58 Months 4 Days 24 If less than one day
.....hrs.min.9. Birthplace Meri, Allegheny, Maryland
(Town, county, and state)10. Usual occupation Carpenter11. Industry or business Celazese Corp.12. Name Jesse James13. Birthplace Allegheny Co. Md14. Maiden name Mary James15. Birthplace Allegheny Co. Md.16. Informant Jesse Sanford JamesAddress Cumberland, Md17. Burial Date thereof March 7, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Greenmount CemeteryLocation Cumberland, Md.18. Funeral director John J. HefnerAddress Cumberland, Md.19. Mar 5 19 46 J. P. Murphy, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 46 at 9:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
.....19..... to19.....
and that I last saw h.....alive on19.....Immediate cause of death Coronary Occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James H. Bouillon, M.D.
M. D. or otherAddress Cumberland, Maryland. Date signed 3-4-46
Deputy Medical Examiner - Allegheny Co.

RECEIVED STATE DEPARTMENT OF HEALTH

STATE OF TEXAS

RECEIVED

MAR 12 1946

BUREAU OF

Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (492)

CERTIFICATE OF DEATH

02234

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny

City or town Chamberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred: 705 Baker St.

How long in hospital or institution?

3. (a) FULL NAME

Jackson, Edith U.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny

City or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Baker St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

218-16-3488

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. - 1903

8. AGE: Years 42 Months 5 Days hrs. min.

9. Birthplace Chamberland, Maryland
(Town, county, and state)

10. Usual occupation Belgian worker

11. Industry or business

12. Name Harry C Jackson

13. Birthplace Md.

14. Maiden name Lena Canizer

15. Birthplace Md.

16. Informant Harry C Jackson

Address Chamberland

17. Burial Burial Date thereof 3/25/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Chamberland

18. Funeral director Romo Stein Inc

Address Chamberland

19. March 24 19 46 J.P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 46 10⁰⁰ AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 19 46 and that I last saw him alive on March 21 19 46

Immediate cause of death Carcinomatosis

Ovarian Carcinoma

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Uterine Fibroids.
abdom. Carcinomatosis Date of op. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.P. Hodges, M.D.

Address Chamberland, Md. Date signed 3/22/46

RECEIVED

APR 3 1946

BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92a)

CERTIFICATE OF DEATH

02235

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 years
Hospital, institution, or street address where death occurred:
16 Valley St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 16 Valley St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Emma Matilda Keller

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife Harry P Keller 6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) March 25, 1865
8. AGE: Years 80 Months 11 Days 13 If less than one day _____ hrs. _____ min.
9. Birthplace Cumberland, Allegheny Co. md
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business at Home
12. Name George Apple
13. Birthplace Germany
14. Maiden name Christine Treiber
15. Birthplace Germany

16. Informant Edward Keller
Address Frederick St, Cumberland Md
17. Burial Date thereof Mar 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md
18. Funeral director John J. Hafer
Address Cumberland Md
19. March 11, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 8 19 46 at 6:00 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 19 45 to March 8 19 46
and that I last saw her alive on 3-6-46 19 _____

Immediate cause of death Coronary fibrillation DURATION 3 mo
Due to _____
Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)
Major findings of operations _____ Date of op. _____
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE R. C. Munnerman M. D. or other
Address Cumberland Md Date signed 9-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Sylvan Retreat
 How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 11 Smith St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Paul Frederick Keller

3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Barbara Santora
 6. (c) If alive, give age 79 years
 7. Birth date of deceased (mo., day, yr.) Oct 13, 1870
 8. AGE: Years 75 Months 5 Days 2 It less than one day
 hrs. min.

9. Birthplace Germany
 (Town, county, and state)
 10. Usual occupation Coal Miner Retired
 11. Industry or business Coal Mines
 12. Name Gottlieb Keller
 13. Birthplace Germany
 14. Maiden name Amelia Stoish
 15. Birthplace Germany

16. Informant John Keller
 Address 429 Homer St, Cumberland Md
 17. Burial March 18, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Unity Lutheran
 Location Cumberland Md
 18. Funeral director John J. Zifer
 Address Cumberland Md
 19. March 18, 46
 (Date rec'd by registrar) Registrar M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15, 1946, at MD
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 29, 1946 to 3.15.46
 and that I last saw him alive on 3.13.46
 Immediate cause of death Infirmities of age
Generalized arteriosclerosis
 Due to arteriosclerosis
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations None Date of op. None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE M. J. Williams
 Address Cumberland Date signed 3.16.46

RECEIVED

MAR 26 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02237

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Rural near McCooles
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town rural near McCooles
(If outside city or town limits, write RURAL and give nearest town)

Street No. R#3 Keyser, W.Va.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Rosetta Leota Knotts

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Lester French Knotts

6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) March 1, 1916

8. AGE: Years Months Days If less than one day
30 0 11 hrs. min.

9. Birthplace Parsons, W.Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John D. Nestor

13. Birthplace Tucker Co. W.Va.

MOTHER 14. Maiden name Minnie A. Fortney

15. Birthplace Preston Co. W.Va.

16. Informant Lester F. Knotts

Address R#3 Keyser, W.Va.

17. Burial Date thereof Mar. 14-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Parsons, W.Va.

18. Funeral director N.H. Rogers

Address Keyser, W.Va.

19. Mar 13 1946 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1946 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1946 to March 12, 1946; and that I last saw her alive on March 11, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Thompson M.D. M. D. or other

Address Keyser, W.Va. Date signed 3-13-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 14 1946
BUREAU OF

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred 433 Homer St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 433 Homer St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Almida Koontz

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Wm Koontz

7. Birth date of deceased (mo., day, yr.) June 13 1863 6. (c) If alive, give age 82 years

8. AGE: Years 82 Months 9 Days 16 If less than one day hrs. min.

9. Birthplace Grassburg N. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home

12. Name Almida Koontz

13. Birthplace N. Va.

14. Maiden name Emily Allender

15. Birthplace N. Va.

16. Informant Almida Koontz

Address Easton

17. (Burial, cremation, or removal. Which?) Burial Date thereof Apr 1 46
(month) (day) (year)

Cemetery or crematory Woods Memorial

Location (East) Cumberland Ind

18. Funeral director Tomie Stein Inc

Address Cumberland

19. (Date rec'd by registrar) March 30, 1946 Registrar J. P. Traubert, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 29, 1946 at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 15, 1946 to Mar. 27, 1946 and that I last saw him alive on Mar. 28, 1946

Immediate cause of death Generalized arteriosclerosis DURATION 5 yrs.

Due to hypertension 20 yrs

Due to phlebotomy 10 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John E. Furest M. D. or other

Address Cumberland Date signed 3/30/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleganyCity or town Smithburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleganyCity or town Smithburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 376 West Hill
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary M. Layman

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Burman Layman

7. Birth date of deceased (mo., day, yr.)

Oct. 21 - 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

77437

hrs.

min.

9. Birthplace

Scotland

(Town, county, and state)

10. Usual occupation

house wife

11. Industry or business

FATHER
MOTHER

12. Name

James D. Nelson

13. Birthplace

Scotland

14. Maiden name

Florence H. Gaine

15. Birthplace

Scotland

16. Informant

Duncan Layman

Address

Cumberland, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 23 - 1946
(month) (day) (year)

Cemetery or crematory

allegany

Location

Smithburg, Md

18. Funeral director

W. J. Davis

Address

Smithburg

19. (Date rec'd by registrar)

3-2246 Mrs. Nancy H. De

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 20 19 46, at 3:00 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Mar 20 19 46 and that I last saw her alive on Oct 14 19 45

Immediate cause of death

Coronary thrombosis

DURATION

sudden
years

Due to

Chronic Myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. J. Davis MD

M. D. or other

Address Frostburg Md Date signed 3-23-46

RECEIVED

MAR 25 1946

BUREAU V F

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

3d

02240

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Yrs.

Hospital, institution, or street address where death occurred:

410 Lehigh St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 410 Lehigh St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jemima Paton Main

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife John P. Main

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1869

8. AGE:

Years

Months

Days

If less than one day

7689

hrs.

min.

9. Birthplace Glasgow, Scotland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name

William Paton

13. Birthplace

Scotland

MOTHER

14. Maiden name

Elizabeth Thompson

15. Birthplace

Scotland16. Informant Mrs. Wm. HagerAddress 410 Lehigh St. Cumberland, Md.17. Burial Date thereof Apr. 1, 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Oak Hill Cem.Location Lonaconing, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. March 30, 1946 J.P. Franklin M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1946, at 11 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 5, 1946 to March 29, 1946and that I last saw her alive on March 25, 1946Immediate cause of death Chronic Myocarditis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R.T. Irevaskis M.D.

M.D. or other

Address Cumberland, Md. Date signed 3/30/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7421

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County AlleganyCity or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Lawrence L. Malloy

3. (b) Social Security Number

705-05-48404. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced marriedB.(b) Name of husband or wife Annie E. Malloy7. Birth date of deceased (mo., day, yr.) March 22, 1879 6.(c) If alive, give age 62 years8. AGE: Years 66 Months 11 Days 28 It less than one day _____ hrs. _____ min.9. Birthplace Mt. Savage, Allegany City, Md.
(Town, county, and state)10. Usual occupation retired11. Industry or business machinist B & O R.R.12. Name George Malloy13. Birthplace Mt. Savage Md.14. Maiden name Mary J. Dull15. Birthplace Pennsylvania16. Informant Joseph MalloyAddress Mt. Savage Md.17. Burial Date thereof March 23, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Patrick's CemeteryLocation Mt. Savage Md.18. Funeral director J. J. AlverstAddress Frostburg Md.19. March 22 19 46 Issued to W. W. W. W. W.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1946, at 10:30 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19, 45 to March 19, 46and that I last saw him alive on March 18, 19 46.

Immediate cause of death _____

Heart Failure DURATION 2 1/2Due to Acute Myocarditis 3 moDue to Coronary Occlusion 6 mo

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE F. Alan J. Murray, MD M. D. or other _____Address Cum gratia Date signed March 2, 1946

RECEIVED
MAR 26 1946
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

02242

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution?

10 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural # 5
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ronald McKenzie

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

June 26, 1945

8. AGE:

Years

Months

Days

If less than one day

88hrs.min.

9. Birthplace

Cumberland, Allegany Co. Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Bernard McKenzie

13. Birthplace

Avilton, Md

MOTHER

14. Maiden name

Violet Grove

15. Birthplace

Avilton, Md.

16. Informant

Bernard McKenzie

Address

Rt 5, Cumberland, Md.

17.

Burial

Date thereof

3/26/46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St Peter & Paul Cemetery

Location

Cumberland, Md.

18. Funeral director

William H. Kight

Address

Cumberland, Md.

19.

March 25, 19 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 19 46 at 5-56 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 23 19 46 to March 24 19 46and that I last saw him alive on March 23 19 46

Immediate cause of death

bronchitis - pneumonia

DURATION

one day

Due to

acute bronchitis2 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. B. Brown, M.D.

M. D. or other

Address

Long Hill

Date signed

3-25-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

02243

Reg. Dist. No. 8

1. PLACE OF DEATH:

County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)Street No. L
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Ross Michaels

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Lawrence Michaels

7. Birth date of deceased (mo., day, yr.)

March 28, 1862

8. AGE: Years Months Days If less than one day

83 11 28 hrs. min.9. Birthplace Farm, Garrett Co. Md. near Barton
(Town, county, and state)10. Usual occupation Horse Work11. Industry or business Own Home

FATHER

12. Name Ross13. Birthplace Farm, Garrett Co. Md. near Barton

MOTHER

14. Maiden name Michaels15. Birthplace Farm, Garrett Co. Md. near Barton16. Informant Mrs. David EvansAddress Barton, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof March 24 1946
(month) (day) (year)Cemetery or crematory Laurel Hill CemeteryLocation Indacow, Md.18. Funeral director Mr. EighonAddress Loraconing, Md.19. March 25 1946
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 1946 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

birth 20 1941 to birth 22 1946and that I last saw him alive on March 21 1946

Immediate cause of death

Coronary Heart Disease

DURATION

Due to

Other conditions

Chronic Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Henry M. Hodgson M.D.

M. D. or other

Address Loraconing, Md. Date signed March 25 1946

RECEIVED
MAR 26 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (700)

CERTIFICATE OF DEATH

02247

9

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Franklin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hrs.

Hospital, institution, or street address where death occurred:

Morris HospitalHow long in hospital or institution? 2 hrs.

3. (a) FULL NAME

John Milford

3. (b) Social Security Number

L

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Child

6. (b) Name of husband or wife

L

7. Birth date of

deceased (mo., day, yr.)

Feb. 23, 19408. (c) If alive, give age L years

8. AGE:

Years

Months

Days

If less than one day

618

.....hrs.

.....min.

9. Birthplace

Lonaconing, Allegany, Md.
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

-FATHER
MOTHER

12. Name

Henry Milford

13. Birthplace

Lonaconing, Md.

14. Maiden name

Nellie Stahm

15. Birthplace

Midland, Md.

16. Informant

Henry Milford

Address

Lonaconing, Md.

17. (Burial, cremation, or removal. Which?)

BurialDate thereof April 3, 1946
(month) (day) (year)

Cemetery or crematory

Oak Hill Cemetery

Location

Lonaconing, Md.

18. Funeral director

M. Eichhorn

Address

Lonaconing, Md.

19.

(Date rec'd by registrar)

4-2

19

46 Mrs. Nancy D. Dye

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Lonaconing
(If outside city or town limits, write RURAL and give nearest town)Street No. Castle St.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH March 31st, 19 46, at 5:40 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to19.....

and that I last saw himalive on19.....

Immediate cause of death

Fractured skull

DURATION

10 minutes.

Due to

Due to

Other conditions Fracture both humeri and both femuræ

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

under investigation Date of 3-31-46Where did injury occur? Lonaconing, Allegany, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) streetMeans of injury struck by auto Injured at work? no

23. SIGNATURE

Phyllis H. Harrison, M.D.

M. D. or other

Address Cumberland, Maryland Date signed 3-31-46

Deputy Medical Examiner - Allegany Co.

RECEIVED

APR 4 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 62244

1. PLACE OF DEATH:

County Westernport, AlleganyCity or town Westernport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Yr.

Hospital, institution, or street address where death occurred:

319 Hammond St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Westernport
(If outside city or town limits, write RURAL and give nearest town)Street No. 319 Hammond
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Jefferson Miller

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Amanda Miller

7. Birth date of

deceased (mo., day, yr.) Mar. 7, 1855.

6. (c) If alive, give age years

8. AGE:

Years

91

Months

Days

5

If less than one day

hrs. min.

9. Birthplace New Germany-Garrett-Md.
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Crispobber Miller13. Birthplace Not Known14. Maiden name Not Known

15. Birthplace

16. Informant Robert MillerAddress Westernport, Md.17. Burial Date thereof Mar. 15, 46.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Philos. Cem.Location Westernport, Md.18. Funeral director Ellsworth S. Boal.Address Westernport, Md.19. March 15, 46 W. J. K. Baker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12 19 46 at 11.30A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 1 19 46 to March 12 19 46
and that I last saw him alive on March 8 19 46

Immediate cause of death

Arterio Sclerosis
chronic nephritisDue to Uremia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Norman Reeves, M.D.
M. D. or other. Westernport Md Date signed 3-14-46

RECEIVED
MAR 16 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

02245

Reg. Dist. No. 6

1. PLACE OF DEATH:

County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Norman Miller

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
-----------------------	----------------------------------	---

8. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Aug. 25, 1935

8. AGE:	Years	Months	Days	It less than one day
	<u>10</u>	<u>6</u>	<u>8</u>	hrs. min.

9. Birthplace Reynolds-Allegany-Md.
(Town, county, and state)10. Usual occupation Student

11. Industry or business _____

12. Name Edward S. Miller13. Birthplace Westernport, Md.14. Maiden name Mary O' Niel.15. Birthplace Westernport, Md.18. Informant Edward S. MillerAddress Barton, Md.17. Burial Date thereof Mar. 5, 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Philos Cem.Location Westernport, Md.Location Ellsworth S. Boal

18. Funeral director _____

Address Westernport, Md.19. Mar. 4, 46 W. K. K. Baker MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3 1946 4:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to Mar 2 1946
and that I last saw him alive on Mar 2 1946Immediate cause of death Sudden cardiac arrest -
Myocardial infarction

DURATION

1 yr

Due to _____

Due to acute Rheumatic fever

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel J. Leever MDAddress Westernport Md. M. D. or other _____Date signed 3/4/46

REC'D
MAR 6 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

22

02246

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 46 yrs.

Hospital, institution, or street address where death occurred:

446 Central Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 446 Central Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Susan Susinda Miller

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Walter F Miller

7. Birth date of deceased (mo., day, yr.)

May 16, 18726. (c) If alive, give age 68 years

8. AGE:

Years

73

Months

9

Days

16

If less than one day

hrs.min.

9. Birthplace

Berlin Somerset Co, Pa
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

At Home

MOTHER FATHER

12. Name

Herman Marty

13. Birthplace

Somerset Co, Pa

14. Maiden name

Sena Bittner

15. Birthplace

Somerset Co, Pa

16. Informant

Walter F. Miller

Address

446 Central Ave - Cumberland Md

17. Burial

Mar 6, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md

18. Funeral director

John J. Hafer

Address

Cumberland Md

19. Mar 5, 1946

J. P. Franklin, M.D.
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2 19 46 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 23, 1946 to March 2, 1946
and that I last saw him alive on March 2, 1946

Immediate cause of death

Acute Bronchitis

DURATION

One week

Due to

Due to

Other conditions

Chronic MyocarditisTwo years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Johnson, M.D.

Address

Cumberland Md

Date signed

3-7-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF THE ARMY

HEADQUARTERS

NOTIFICATION

RECEIVED
MAR 12 1946
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yrs.

Hospital, institution, or street address where death occurred:

355 Balto. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 355 Balto. Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

ANDREW J. MOONEY

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Johanna Dagnon Mooney7. Birth date of deceased (mo., day, yr.) Mar. 17, 1875 8. (c) If alive, give age years8. AGE: Years 71 Months 0 Days 2 If less than one day hrs. min.9. Birthplace Kings Co. Ireland
(Town, county, and state)10. Usual occupation Retired Western Maryland
Railway Employee

11. Industry or business

12. Name Andrew Mooney
13. Birthplace Ireland14. Maiden name Margaret Condon
15. Birthplace Ireland16. Informant Frank Litten
Address 489 Goethe St. Cumberland, Md.17. Burial Mar. 23, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. PatricksLocation Cumberland Md.18. Funeral director Charles L. GeorgeAddress 202 Greene St. Cumberland, Md.19. March 22, 1946 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19, 46 at 1:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3, 1946 to March 19, 1946
and that I last saw him alive on March 15, 1946

Immediate cause of death

chronic myocarditis

DURATION

2 yrs.Due to extremities

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. Brings M.D.

M.D. or other

Address 59 Greene St. Cumberland Date signed 3-21-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED

RECEIVED
MAR 26 1946
BUREAU V.S.

2411 N. Charles St., Baltimore (570)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County GrantCity or town Gormanias
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hilda Mae Moreland

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

December 24, 1945

8. AGE:

Years

Months

Days

If less than one day

27

hrs.

min.

9. Birthplace

Gormanias, West Virginia

(Town, county, and state)

10. Usual occupation

Infant

11. Industry or business

FATHER

12. Name Clarence D. Moreland13. Birthplace West Virginia

MOTHER

14. Maiden name Twila Rotruck15. Birthplace Maryland

16. Informant

Memorial Hospital

Address

Cumberland, Maryland

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof Mar. 4, 1946
(month) (day) (year)

Cemetery or crematory

Moreland Cem
Mar Bismarck, W. Va.

Location

O. F. Sharpless
Blaine, W. Va.

18. Funeral director

Address

19.

Mar 3, 46
(Date rec'd by registrar)

19.

J. P. Franklin M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 46 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 26th 19 46 to March 1 19 46and that I last saw her alive on March 1st 19 46

Immediate cause of death

DURATION

Bronchial Pneumonia 4 days

Due to

Due to

Other conditions

Congestive cardiopathy 2 mos

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

P. J. Owens M.D.
M. D. or otherAddress Cumberland, Md Date signed 3-2-46

RECEIVED

MAR 12 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

CERTIFICATE OF DEATH

Reg. Dist. No. 19-27-02250 6

1. PLACE OF DEATH:

County Allegany
City or town Mc Coole
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

David Boyd Murphy

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Hazel Murphy

7. Birth date of deceased (mo., day, yr.)

Aug. 14, 1872

6. (c) If alive, give age 42 years

8. AGE:

Years

Months

Days

If less than one day

73

6

4

hrs.

min.

9. Birthplace

Schell-Mineral-W. Va.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

William Murphy

13. Birthplace

Ireland

MOTHER

14. Maiden name

Not Known

15. Birthplace

16. Informant

Walter Murphy

Address

Mc Coole, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 21, 46
(month) (day) (year)

Cemetery or crematory

Rehobeth Cem.

Location

Mt. Storm, W. Va.

18. Funeral director

Ellsworth S. Boal

Address

Westernport, Md.

19. (Date rec'd by registrar)

Mar. 21 1946

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

W. Va.

County

Grant

City or town

Mt. Storm

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

219-03-5175

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 18

1946

at

4.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 10 1946

19

March 18 1946

and that I last saw him alive on

March 17

1946

Immediate cause of death

Myocardial Degeneration.

DURATION

8mo

Due to

Cardio Renal Disease,

2yrs

Due to

Arterio Sclerosis,

2yrs

Other conditions

Cardiac and Renal dropsy.
or edema.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

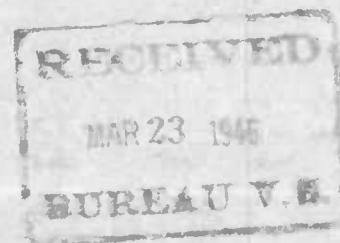
23. SIGNATURE

Piedmont W. Va.

M. D. or other

Address

Date signed 3/20 46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

02251

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

22 Bedford St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 22 Bedford St.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

James Wm. Myers

3. (b) Social Security Number

219-03-8141

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

8. (b) Name of husband or wife

Hazel HuttonB. (c) If alive, give age 46 years

7. Birth date of

deceased (mo., day, yr.)

March 8, 1906

8. AGE:

Years

Months

Days

If less than one day

4008

hrs.

min.

9. Birthplace

Lonaconing, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

clerk

11. Industry or business

W. and Railway

12. Name

John H. Myers

13. Birthplace

Hoboken, N. J.

14. Maiden name

Lucy Agnes Deasdale

15. Birthplace

Lonaconing

18. Informant

Mrs. John H. Myers

Address

22 Bedford St - Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

March 19, 1946
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Haley

Address

Cumberland, Md.

19. March 19, 46

(Date rec'd by registrar)

J. P. Franklin, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1946 at 1846 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from birth 1906 to March 16, 1946and that I last saw him alive on March 18, 1946

Immediate cause of death

Coronary Thrombosis

DURATION

3 1/2

Due to

Diabetes

Due to

Cerebral thrombosis

Other conditions

2 years ago with
paralytic stroke

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.

M. D. or other

Address 41 Green St.Date signed March 19, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46a

CERTIFICATE OF DEATH

02252 4

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
619 Fairview Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Fairview Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James Edward Nixon

3.(b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Carolyn M. Nixon

8.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) August 15, 1889

8. AGE: Years 56 Months 7 Days 16 hrs. min.

9. Birthplace Oldtown, Maryland
(Town, county, and state)

10. Usual occupation Owner & operator

11. Industry or business Woodworking plant

12. Name Harrison Nixon

13. Birthplace Md.

14. Maiden name Lavinia Barth

15. Birthplace Md.

16. Informant Mrs. Carolyn Nixon

Address Cumberland, Md

17. Burial Date thereof April 3, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hester

Address Cumberland, Md.

19. April 2, 1946 (Date rec'd by registrar)

Registrar Joseph P. Brubaker Md

MEDICAL CERTIFICATION

2D. DATE OF DEATH March 31 1946 at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1945 to March 31, 1946 and that I last saw him alive on 3/31/46

Immediate cause of death Complications of
myocardial infarction

Due to

Due to

Other conditions Cerebral hemorrhage

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John H. Rogers MD M. D. or other

Address Cumberland Md Date signed 4/2/46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

02253

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 weeks
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
City or town Richwood, West Va.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Leorthe Alberta Petenbrink

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Byron Petenbrink

7. Birth date of deceased (mo., day, yr.) Jan. 5th, 1923 8. (c) If alive, give age 25 years

8. AGE: Years 23 Months 2 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace Richwood, Allegany, Md.
(Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business _____

12. Name Frank W. Wanner

13. Birthplace Richwood, Md.

14. Maiden name Elizabeth Rose

15. Birthplace Richwood, Md.

16. Informant Mr. Frank Wanner

Address Richwood, Md.

17. Burial Date thereof 3-22-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Richwood Cemetery

Location Richwood, Md.

18. Funeral director Joe of Richwood

Address Frostburg, Md.

19. 3-22 19 46 Miss Nancy H. De

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 19 46 at 3:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 19 46 to March 19 19 46 and that I last saw him alive on March 19 19 46

Immediate cause of death Bilateral Fungus DURATION 6 wks

Due to (Lab report suggested monilia)

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____ Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Hilda Jankovsky, M.D.

Address Frostburg Date signed 3/21/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 25 1946

BUREAU V S

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

02254

CERTIFICATE OF DEATH



Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 301 Mass. Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

John D. Redhead

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Louise Redhead

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1865

8. AGE: Years 80 Months 7 Days 13 If less than one day
 hrs. min.

9. Birthplace New York
(Town, county, and state)10. Usual occupation Retired11. Industry or business Miner12. Name John Redhead13. Birthplace England14. Maiden name Barbara Connor15. Birthplace Ireland16. Informant Memorial HospitalAddress Cumberland, Md.17. Burial Date thereof Mar. 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Otter BeinLocation Stoyestown, Penna.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. March 12, 46 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 11, 1946, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 3, 1946 to March 11, 1946
 and that I last saw him alive on March 11, 1946

Immediate cause of death

DURATION

Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. H. Maskever

M. D. or other

Address 49 Green St Date signed 3-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

02255

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 102 Center St
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Launcelot Cleavert Richardson

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Annie Richardson

B. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) August 5, 1871

8. AGE: Years 74 Months 7 Days 25 It less than one day hrs. min.

9. Birthplace Eckhart, Allegany Cty., Md.
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business WPA project

12. Name George Richardson

13. Birthplace England

14. Maiden name Roseann McDonald

15. Birthplace Eckhart, Md.

16. Informant George Richardson,

Address Frostburg, Md.

17. Burial Date thereof April 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director J. J. Durst,

Address Frostburg, Md.

19. 4-1 46 Ms. Nancy H. Rie
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH March 29th., 19 46 at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on 19.

Immediate cause of death

Fractured skull at base.

DURATION

killed instantly

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations no operation

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-29-46

Where did injury occur? Frostburg, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) R.R. right of way

Means of injury fall from cliff Injured at work? no

23. SIGNATURE James H. Worsen, M.D. M. D. or other

Address Cumberland, Maryland Date signed 3-30-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 9-4-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 4 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year
of birth of deceased is
shown on

FILM No. I 01 APR - 9 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

02256

Reg. Diat. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 yrs
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 30 Mill St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary Josephine Rizer

3. (b) Social Security Number

✓

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

B. (b) Name of husband or wife Robert N. Rizer

7. Birth date of deceased (mo., day, yr.) Sept. 25 1886 6. (c) If alive, give age 58 years

8. AGE: Years 67 Months 5 Days 28 If less than one day hrs. min.

9. Birthplace Benacoming, Allegany, Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John T. Clark

13. Birthplace Not known

14. Maiden name Miss Jean Platter

15. Birthplace Not known

16. Informant Mrs Katherine Rizer

Address 101 Bayview St. Frostburg, Md

17. Burial Date thereof 3-27-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Calvary Cemetery

Location Frostburg, Md

18. Funeral director James J. Rizer

Address Frostburg, Md

19. 3-27 19 46 Mrs. Nancy A. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 24 19 46 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 46 to Mar 24 19 46

and that I last saw him alive on Mar 23 19 46

Immediate cause of death Chronic myocarditis

Due to ✓

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. Lane, Jr. MD M. D. or other MD
Address Frostburg, Md Date signed Mar 25 1946

RECEIVED
MAR 30 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

02257

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 157 POLK STREET (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

MISS. EMMA ROBB

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth data of deceased (mo., day, yr.) February 8 1864

8. AGE: Years Months Days If less than one day
82 0 26 hrs. min.

9. Birthplace MARYLAND Frostburg, Allegany Co. (Town, county, and state)

10. Usual occupation HOUSEWORK

11. Industry or business

12. Name GEORGE ROBB

13. Birthplace GERMANY

14. Maiden name SARAH ANN RICE

15. Birthplace MARYLAND

16. Informant ROSE ROBB

17. Address 157 POLK ST., CUMBERLAND, MD.

18. Burial Date thereof 3/7/46 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

19. Funeral director William H. Kight

Address Cumberland, Md.

20. Mar 6 1946 J. P. Franklin, M. D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 4, 1946 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-35 1946 to 3-4-46 and that I last saw him alive on 3-4-46

Immediate cause of death

Broncho Pneumonia

Generalized Arterio Sclerosis

Diabetes Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

3.5.46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MINISTER OF THE INTERIOR

DEPARTMENT OF THE INTERIOR

RECEIVED
MAR 12 1946
BUREAU V.S.

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

02258

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Rural # 1, Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 Years 28 Days
Hospital, institution, or street address where death occurred:
Rural # 1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural # 1.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Frances Maxine Roberson

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 23, 1936 6. (c) If alive, give age years

8. AGE: Years 10 Months 0 Days 28 hrs. min.

9. Birthplace Cumberland, Allegany County, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Laurence M. Roberson

13. Birthplace Kirby, W. Va.

MOTHER 14. Maiden name Mary Allen

15. Birthplace Parsons, W. Va.

18. Informant Laurence M. Roberson

Address Rt # 1, Cumberland, Md.

17. Burial Date thereof 3/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. March 23, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1946 at 10-30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15/46 to 3/21/46 and that I last saw him alive on 3/21/46

Immediate cause of death myocardial infarction DURATION

Due to arteriosclerosis

Due to

Other conditions spastic paralysis from birth
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin M. D. or other

Address 122 Bedford St Date signed 3/23/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 26 1946
BUREAU V.S.

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. WILLIAMS & DR. ENFIELD

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-F

02259

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: ALLEGANY
County: CUMBERLAND, MD.
City or town: (if outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(if outside city or town limits, write RURAL and give nearest town)
Street No.: 23 NEW HAMPSHIRE
(if rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME
MRS. GERTRUDE ROWLEY

3. (b) Social Security Number
None

4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, married, widowed, or divorced: WIDOWED

6. (b) Name of husband or wife: MURTEN ROWLEY
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): OCT. 28 1889

8. AGE: Years: 56 Months: 4 Days: 7
It less than one day hrs. min.

9. Birthplace: WEST VIRGINIA
(Town, County, and State)

10. Usual occupation: SEAMSTRESS
11. Industry or business: MEMORIAL HOSPITAL

12. Name: JOHN DOMAN
13. Birthplace: WEST VIRGINIA

14. Maiden name: MOLLY STUMP
15. Birthplace: WEST VIRGINIA

16. Informant: SELF

Address: 23 NEW HAMPSHIRE CUMBERLAND, MD.
17. Burial Date thereof: 8 March 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: LOUIS STEIN, INC.
Address: Cumberland, Md.

19. March 8 46 J. P. Franklin M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH: MARCH 5, 1946
19. at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/23/46 to 3/5/46
and that I last saw her alive on 3/5/46

Immediate cause of death: Carcinoma of Liver
DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Liver
Date of op. 3/6/46

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. P. Franklin M.D.
Address: Cumberland, Md. Date signed: 3/5/46

RECEIVED

MAR 12 1946

RECEIVED

56 Howard Sunderland MD 3/18/46

RECEIVED
MAR 25 1946
BUREAU V.S.

RECEIVED
MAR 25 1946
BUREAU V.S.

705-09-8684

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02261

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 48 yrs

Hospital, institution, or street address where death occurred:

714 Virginia Ave

How long in hospital or institution:

3. (a) FULL NAME

Charles Henry Schaub4. Sex Male5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Ernest Brandt7. Birth date of deceased (mo., day, yr.) Oct 10 18768. AGE: Years 69 Months 4 Days 27 If less than one day9. Birthplace Baltimore Md
(Town, county, and state)10. Usual occupation School Master11. Industry or business Retired 7 yrs.12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant Ernest SchaubAddress 214 Virginia Ave, Cumberland Md17. Burial Date thereof Mar 7 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland Md18. Funeral director Louis Stein, IncAddress Cumberland Md19. Mar. 6, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 714 Virginia Ave
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 46 at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 5 1944 to March 4 1946and that I last saw him alive on March 5 1946Immediate cause of death Coronary OcclusionDURATION 2 hrsDue to ArteriosclerosisDue to MyocarditisDue to Diabetes

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide M Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. B. Oliver MDM. D. or other B. B. Oliver MDDate signed 3/14/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

✓

RECEIVED
MAR 12 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

802

02262

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County ALLEGANY

City or town CORRIGANSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

SEEDERS, JOHN WM. JR.

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE

WHITE

INFANT

B.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 4, 1946

8. AGE: Years Months Days If less than one day

30 2 27 hrs. min.

9. Birthplace Cumberland Alleg. Co., Md.
(Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

12. Name SEEDERS, JOHN WM. SR.

13. Birthplace MD.

14. Maiden name Clites, Juanita

15. Birthplace MD.

16. Informant MEMORIAL H. SPITAL

Address CUMBERLAND, MD.

17. Burial, cremation, or removal. Which? Date thereof April 2 1946
(month) (day) (year)

Cemetery or crematory Porter

Location Shynman, Pa. R.D. 1.

18. Funeral director Harvey H. Leigler

Address Shynman, Pa.

19. Date rec'd by registrar April 2 46 J.P. Franklin, M.D.
(Date rec'd by registrar) (month) (day) (year) Registrar

DR. TOPPER

MEDICAL CERTIFICATION

20. DATE OF DEATH MAR. 31 1946 at 12 NOON

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 30 1946 to Mar 31 1946

and that I last saw him alive on 19

Immediate cause of death Encephalitis

DURATION

4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Topper M.D.

M. D. or other

Address Shynman, Pa. Date signed 4.1.46.

MARGIN RESERVED FOR BINDING

VS A15

9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1192

02263

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo.

Hospital, institution, or street address where death occurred:

1012 Ella Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County AlleganyCity or town Cumtland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1012 Ella Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Richard Sirtangr

3. (b) Social Security Number

none4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Jan 17 1946

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Cumtland Ind.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

March 30, 46J. P. Franklin, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 28 19 46 at 11:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 25 19 46 to March 28 19 46and that I last saw him alive on March 28 19 46

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

IMAGE NOT TRANSMITTED DUE TO DELETION

RECEIVED

ARTESIAN WATER

SAG CONTENT

RECEIVED
APR 3 1946
BUREAU V.S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02264

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 515 Eastern Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

GEORGE SHAFFER

3. (b) Social Security Number

577-14-3439

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6. (b) Name of husband or wife MARY JONES

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) MAY 28, 1905

8. AGE: Years Months Days If less than one day
40 9 13 hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation UNABLE TO WORK

11. Industry or business Keli's Garage

12. Name HAROLD SHAFFER

13. Birthplace MARYLAND

14. Maiden name CARRIE PORTER

15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial Date thereof Mar. 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Zion Memorial Burial Park

Location Bedford Road

18. Funeral director Charles L. George

Address Cumberland, Md.

19. March 14, 46 Joe P. Franklin MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 13 19 46 at 7:13 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/11/46 19 46 to 3/13/46 19 46
and that I last saw h. alive on 3/13/46 19 46

Immediate cause of death

Cardiac vascular disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Cumberland, Md. Date signed 3/13/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2320

CERTIFICATE OF DEATH

Reg. Dist. No. 02265

1. PLACE OF DEATH:

County... Allegheny
 City or town... Westport - Rural
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yearsHospital, institution, or street address where death occurred: RFD-1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AlleghenyCity or town... Westport
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mary Adeline Shaffer

3.(b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife... David Shaffer6.(c) If alive, give age... 86 years7. Birth date of deceased (mo., day, yr.) May 14, 18708. AGE: Years 75 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace... Cottleville, Boyd, Kentucky
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

12. Name... Alderson Hunt13. Birthplace... Not known14. Maiden name... Amanda Taylor15. Birthplace... Not known16. Informant... Mrs. Janice ArthurAddress... Westport, Md17. Burial Date thereof... 3/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Olds CemeteryLocation... Westport, Md18. Funeral director... Ellsworth S. BoalAddress... 111 Church St. Westport, Md19. Mar 23 46 (Date rec'd by registrar) Registrar W. D. or other

MEDICAL CERTIFICATION

20. DATE OF DEATH... Mar. 20 19... 46 at 6:20 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19... 46, to March 20 19... 46, and that I last saw him... ex. alive on March 20 19... 46Immediate cause of death... Cerebral Hemorrhage DURATION 1 dayDue to... arteriosclerosis
hypertension

Due to... ..

Other conditions... ..

(Include pregnancy within 3 months of death)

Major findings of operations... ..

Autopsy results... ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... .. Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... P. Berry, M.D. M. D. or otherAddress... Westport, Md Date signed 3/23/46

RECEIVED
MAR 25 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1946)

02266

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County AlleganyCity or town Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Emma Sigler

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widow8. (b) Name of husband or wife James Sigler7. Birth date of deceased (mo., day, yr.) May 24, 1861.

8. (c) If alive, give age years

8. AGE: 84 Years 9 Months 7 Days It less than one day9. Birthplace Grafton-Taylor-W. Va.

(Town, county, and state)

10. Usual occupation House-wife11. Industry or business Own home12. Name Jacob Forthman13. Birthplace Germany14. Maiden name Marcellenia Blakney15. Birthplace Martinsburg, W. Va.16. Informant Mrs. Joseph ShuhartAddress Barton, Md.17. Burial Philos Cem.(Burial, cremation, or removal, Which?) Date thereof Mar 4, 1946Cemetery or crematory Philos Cem.Locallo Westernport, Md.18. Funeral director Ellsworth S. Boal.Address Westernport, Md.19. March 4, 1946

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 1 1946 at 5P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 1946 to Mar 1 1946 and that I last saw him alive on Feb 2nd 1946Immediate cause of death Chronic cardiac vascular

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward J. Reeves MD

M. D. or other

Address Westernport, Md. Date signed 3/5/46

RECEIVED

RECEIVED

RECEIVED

MAR 6 1946

BUREAU V.R.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 412 Holland Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Georgia Smith

3. (b) Social Security Number

220-03-7857

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Robert E. Smith

6. (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) August 10, 1909

8. AGE: Years 36 Months 7 Days 6 If less than one day
.....hrs.min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife - Worker

11. Industry or business Union Laundry Co.

12. Name Wilbur Hardy

13. Birthplace West Virginia

14. Maiden name Ella ~~Smith~~ Cheshire

15. Birthplace West Virginia

16. Informant Memorial Hospital

Address Cumberland, Maryland

17. Burial Date thereof March 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Burial Park

Location Cumberland, Maryland

18. Funeral director William H. Kight

Address Cumberland, Maryland

19. March 19, 1946 J. L. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 19 46, at 5:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14, 1946 to March 16, 1946
and that I last saw her alive on March 16 (5:57 PM) 1946

Immediate cause of death Respiratory and Cardiac Failure

DURATION

Due to Bilateral Lobar Pneumonia and acute myocarditis 2 days

Due to Complication Septic Sore Throat

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Richard W. Trevasakis Jr. M. D. or other
Address Cumberland, Md. Date signed 3/18/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(1370)

02268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Co. Infirmary

How long in hospital or institution?

21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 142 Bedford St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Hannah E. Smith

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Geo. H. A. Smith

7. Birth date of

deceased (mo., day, yr.)

March 16 1879

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

661123

hrs.

min.

9. Birthplace

Hampshire Co. W. Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

James Hance

13. Birthplace

W. Va.

MOTHER

14. Maiden name

Elizabeth Cripp

15. Birthplace

W. Va.

16. Informant

Bertice Katherine Smith

Address

142 Bedford St.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Mar 10 '46

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19. March 10, 1946

(Date rec'd by registrar)

J. P. Franklin M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 9 1946 at 6:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2:19 to 3:09and that I last saw him alive on 3:06 1946

Immediate cause of death

Cardiovascular renal disease

DURATION

Due to

Due to

Other conditions

None

(Include pregnancy within 8 months of death)

Major findings of operations

None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Dr. F. Williams

M.D. or other

Address Cumberland Date signed 5.9.46

RECEIVED

MAR 20 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02269

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Midland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midland
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Mary Fair Smith

3.(b) Social Security Number

1

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife George Smith

7. Birth date of deceased (mo., day, yr.) Feb 25 - 1871 (c) If alive, give age 75 years

8. AGE: Years 75 Months 0 Days 6 If less than one day _____ hrs _____ min.

9. Birthplace Ayrshire Scotland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name William Fair

13. Birthplace Scotland

14. Maiden name Catherine Mooney

15. Birthplace Scotland

16. Informant Mary Smith

Address Midland

17. Burial Date thereof Mar 4 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Belle Vue Cemetery

Location Midland, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. March 3 1946 D. E. Craft Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 1946 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

from 1944 to Mar 1 1946

and that I last saw him alive on Feb 15 1946

Immediate cause of death chronic interstitial nephritis

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Henry M. Hodgson M.D.

M. D. or other

Address Lonaconing, Md.

Date signed Mar 3 1946

MARGIN RESERVED FOR BINDING

VS A15

9-45

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1946

BUREAU

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-C

02270

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 10 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1 Box 349
(If rural, give LOCATION)

2.(a) If veteran, name war World War 11

3.(a) FULL NAME

Russell Edward Smith

3.(b) Social Security Number

2 20-10-4120

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
-----------------------	----------------------------------	--

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1918

8. AGE:	Years	Months	Days	if less than one day
	<u>28</u>	<u>2</u>	<u>7</u>hrs.min.

9. Birthplace Vindex, Md.
(Town, county, and state)

10. Usual occupation Labor

11. Industry or business W. Md. R.R.Co. Shops

FATHER 12. Name Joseph Smith

13. Birthplace West Va.

MOTHER 14. Maiden name Teresa Wright

15. Birthplace Maryland

18. Informant Mr. Joseph Smith

Address R.D. #1 Box 349 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar. 15, 1946
(month) (day) (year)

Cemetery or crematory Porter Cemetery

Location Near Eckhart, Md.

18. Funeral director Charles L. George

Address Cumberland, Md.

19. March 14, 46 (Date rec'd by registrar) Joe P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH March 12th, 19 46, at 12.35 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....
Fractured skull,
parietal region

DURATION
25 min.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

under investigation 3-12-46

Accident, suicide, or homicide..... Date of.....

Where did injury occur? Cumberland, Allegany, Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) street

Means of injury auto accident Injured at work? no

23. SIGNATURE.....Phineas H. Boyer, M.D.

Address Cumberland, Maryland M. D. or other

Date signed 3-13-46

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V S.

APPEAL LOG

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

Reg. Dist. No. 02271 9

1. PLACE OF DEATH:

County alleganyCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleganyCity or town Smithsburg
(If outside city or town limits, write RURAL and give nearest town)Street No. Hunter Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

unknown

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

741872

hrs. min.

9. Birthplace

(Town, county and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar 28-1946
(month) (day) (year)

Crematorium crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46 Mrs Haddy & Rose

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 46, at 8:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/17 19 46, to 3/27 19 46and that I last saw him alive on 3/27 19 46

Immediate cause of death

Coronary Disease

DURATION

2 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Hilda J. Walters, MD
Address Frostburg MD M. D. or otherDate signed 3/27/46

RECEIVED
MAR 30 1946
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

02272

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Kelly Springfield Fire Co.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State md County Allegany
City or town Twiggstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Cumberland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clay Wilson Stewart

3. (b) Social Security Number

214-05-5807

4. Sex 5. Color or race 6. (c) Single, married, widowed, or divorced

Male white Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Mar 3, 1900
6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

46 0 20 hrs. min9. Birthplace Twiggstown, Allegany Co. Md.
(City, town, county, and state)10. Usual occupation Shipping Dept. Checker11. Industry or business Kelly Springfield Fire Co.12. Name John J. Stewart13. Birthplace Unknown14. Maiden name Amanda Neal15. Birthplace Unknown16. Informant Addie HewellAddress Route 2 Cumberland, Md.17. Burial Date thereof Mar 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland Md18. Funeral director John J. HalerAddress Cumberland, Md.19. March 25, 46 J. P. Chaublin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23rd., 1946 at 8:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Coronary Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Phineas H. Bowser M.D.Address Cumberland, MarylandDate signed 3-23-46Deputy Medical Examiner = Allegany Co.

MARGIN RESERVED FOR BINDING

VS A15 945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU V S

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Hampshire

City or town Green Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George R. Stewart

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Widowed

6.(b) Name of husband or wife Fannie Lewis

7. Birth date of deceased (mo., day, yr.)

January 16, 1871

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

75

1

26

hrs.

min.

9. Birthplace West Virginia, Hampshire County
(Town, county, and state)

10. Usual occupation Unable to work - Retired

11. Industry or business B. and O. R. R. Co.

MOTHER FATHER

12. Name

George W. Stewart

13. Birthplace

West Virginia

14. Maiden name

Lydelia York

15. Birthplace

West Virginia

16. Informant Memorial Hospital
Address Cumberland, Maryland

17. Burial Date thereof Mar 15 - 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Forrest Glen

Location

Greenspring, W. Va.

18. Funeral director

Thrush's

Address

Romney, W. Va.

19. March 14, 46 Joe F. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1946 at 10:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-5- 1946 to 3-12- 1946

and that I last saw him alive on 3-12- 1946

Immediate cause of death _____ DURATION

Carcinoma prostate

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations no operation Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place, (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Howard P. Tolson, M.D. M. D. or other

Address Cumberland, Md Date signed 3-15-46

MARGIN RESERVED FOR BINDING

VS A15 9.45 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B

02274

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumtburland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred

159 1/2 E. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Baylango County AlleganyCity or town Cumtburland
(If outside city or town limits, write RURAL and give nearest town)Street No. 139 1/2 E. Centre St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Hazel Webb Strong

3. (b) Social Security Number

None4. Sex Female 5. Color of face White 6.(a) Single, married, widowed, or divorced Divorced6.(b) Name of husband or wife Earl Strong7. Birth date of deceased (mo., day, yr.) June 26 19008. AGE: Years 45 Months 8 Days 28 If less than one day
.....hrs.min.9. Birthplace Everett Pa
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Charles Melosh13. Birthplace Pa14. Maiden name Mrs. Grubbs15. Birthplace Pa16. Informant Mrs. Nora MeloshAddress 44 Bedford St. Cumtburland17. Burial Date thereof June 28 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Cem.Location Cumtburland18. Funeral director Louis SteinAddress Cumtburland19. March 28, 19 46 J. P. Franklin M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 25 19 46 at 10:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 46 to March 25 19 46
and that I last saw him or alive on March 24 19 46Immediate cause of death Tuberculosis in DURATION 1 year
lungDue to Exhaustion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. N. Frank M. D. or otherAddress Cumtburland Md Date signed 4/26/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 3 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year
of birth of deceased is
shown on

FILM No. I 0 1 MAR 19 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-2

CERTIFICATE OF DEATH

02275

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegheny

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Misses Hospital

How long in hospital or institution?

1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Allegheny

City or town Eastport, N.Y.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas G. Sullivan

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Sept. 14 - 1865

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

77

5

30

hrs.

min.

9. Birthplace

Castle Lyons, Cork, Ireland
(Town, county, and state)

10. Usual occupation

Retired, waymaster

11. Industry or business

Coal Mining

FATHER

12. Name

Michael Sullivan

13. Birthplace

Ireland

MOTHER

14. Maiden name

William Lee

15. Birthplace

Ireland

16. Informant

Miss Ellen Byrne

Address

Eastport, N.Y.

17. Burial

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Mar. 4 - 1946

(month) (day) (year)

Cemetery or crematory

St. Michael's Cemetery

Location

Frostburg, Md.

18. Funeral director

James D. Baker

Address

Frostburg, Md.

19. 3-7

19. 46

(Date rec'd by registrar)

19. 46

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19. 46

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 46 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/5 19 46 to 3/5 19 46

and that I last saw him alive on 3/5 19 46

Immediate cause of death

Uremia

DURATION

Due to

Arteriosclerotic heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

_____ Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury

Injured at work?

23. SIGNATURE

Hildegarde Welby, M.D.

Frostburg, Md. M. D. or other _____ Date signed 3/7/46

RECEIVED

MAR 9 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 022760

1. PLACE OF DEATH:

County Allegany
 City or town Barrellsville near Mt. Savage
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Allegany
 City or town Barrellsville near Mt. Savage
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Ms Jackie May Teter

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

Don C. Teter

7. Birth date of deceased (mo., day, yr.)

May 4, 19098. (c) If alive, give age 38 years

8. AGE:

Years

Months

Days

If less than one day

361011

hrs.

min.

9. Birthplace

Randolph Co. W. Va
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

At Home

MOTHER FATHER

12. Name

James Wm Carr

13. Birthplace

Randolph Co. W. Va.

14. Maiden name

Elizabeth Mich

15. Birthplace

Randolph Co. W. Va

16. Informant

Mrs Eliz. Wyatt

Address

Mt Savage Ind.

17. (Burial, cremation, or removal. Which?)

BurialDate thereof Mar 18, 1946
(month) (day) (year)

Cemetery or crematory

Mt Savage Methodist

Location

Mt Savage, Ind.

18. Funeral director

John J. Zaker

Address

Cumberland, Ind.

19.

(Date rec'd by registrar)

19

46Varian McDemitt

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 14 1946 to March 14 1946and that I last saw him alive on March 17 1946

Immediate cause of death

Tuberculosis lungs

DURATION

year

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Blane M. Brindley

M. D. or other

Address

411 E. 1st St. Cumberland, Ind.Date signed April 1, 1946

RECEIVED
MAR 26 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

Reg. Dist. No. 02277 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 73 years

Hospital, institution, or street address where death occurred:

Memorial Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 406 Polaski St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Edward Thompson

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1946, at 1:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8:13 1943 to 3:6 1946
and that I last saw him alive on 3:6 1946

Immediate cause of death

Carcinomatous
of abdominal
viscera

DURATION

Due to

Due to

Other conditions

Carcinoma
of stomach
(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma
of stomach Date of op. Nov. 44

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. P. Franklin, M.D.
Address Cumberland Date signed 3.8.4617. (Burial, cremation, or removal. Which?) Date thereof March 9, 1946
(month) (day) (year)Cemetery or crematory Roschill CemeteryLocation Cumberland, Md.18. Funeral director John J. HefnerAddress Cumberland, Md.19. March 9, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF TEXAS
COUNTY OF DALLAS

RECEIVED
MAR 12 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 80-6

CERTIFICATE OF DEATH

02278

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 Years

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 9 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town 111 ARCH ST. CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)Street No. 111 ARCH ST.
(If rural, give LOCATION)2.(a) If veteran, name war World War 1.

3. (a) FULL NAME

TRAIL, BENJAMIN H. MR.

3. (b) Social Security Number

705-07-6878

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITESINGLE

8. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) NOV. 12 18898. AGE: Years Months Days It less than one day
56 4 11 _____ hrs. _____ min.9. Birthplace MARYLAND
(Town, county, and state)10. Usual occupation RETIRED ENGINEER

11. Industry or business

12. Name HUEY TRAIL13. Birthplace MARYLAND14. Maiden name RACHEL ROBERTS15. Birthplace MARYLAND16. Informant Memorial HospitalAddress Cumberland, Md.17. Burial Date thereof 3/26/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. March 25 46 J. P. Chaublin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 23 19 46 at 10:45 ^A21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1 - 1946 March 23 1946and that I last saw him alive on March 23 1946

Immediate cause of death

Encephalitis

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

March 25 46 J. P. Chaublin, M.D.
Address Date signed

RECEIVED

APR 3 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

02279

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, institution, or street address where death occurred:
48 Browning St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 48 Browning
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Barrie V. Twigg

3. (b) Social Security Number
214-05-7016

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 5 1882 6.(c) If alive, give age years

8. AGE: Years 63 Months 10 Days 15 If less than one day hrs. min.

9. Birthplace Oldtown Ind.
(Town, county, and state)

10. Usual occupation Presser

11. Industry or business Cannery

12. Name Charles H. Twigg

13. Birthplace Maryland

14. Maiden name Susan Farlow

15. Birthplace Maryland

16. Informant Miss Cora M. Twigg

Address 125 Springdale St., Cumberland, Md.

17. Burial Date thereof 23 MAR 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Maryland.

18. Funeral director Louis Stein, Inc.

Address Cumberland, Md.

19. March 22 19 46 Joe P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 46 at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 19 46 to March 20 19 46 and that I last saw him alive on March 18 19 46

Immediate cause of death Chronic Myocarditis

Due to Coronary Thrombosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Clayton J. Jurek M. D. or other

Address Cumberland Date signed 3/21/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 26 1946

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
 County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 30 Yrs.
 Hospital, institution, or street address where death occurred:
 1123 Bedford St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Allegany
 City or town..... Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 1123 Bedford St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
 Alice Minerva Valentine

3. (b) Social Security Number
 None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Frank B. Valentine
 Deceased 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) July 30, 1868
 8. AGE: Years 77 Months 7 Days 3 If less than one day..... hrs. min.

9. Birthplace Corrigansville, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name John Martin
 13. Birthplace W. Va.
 14. Maiden name Mary Printy
 15. Birthplace Md.

16. Informant Jesse F. Valentine
 Address Ridgely, W. Va.
 17. Burial Date thereof Mar. 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cem.
 Location Cumberland, Md.
 18. Funeral director Charles L. George
 Address Cumberland, Md.

19. March 5, 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1942 to Mar. 3, 1946 and that I last saw him alive on Mar. 3, 1946.

Immediate cause of death Hypertensive cardio-renal disease
 DURATION 2 yrs.

Due to disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. P. Franklin, M.D.

Address Medical Bldg Date signed 3-5-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BY ORDER OF THE SECRETARY OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

HEADQUARTERS, ARMY

FORM NO. 10-1

OFFICE OF THE SECRETARY OF THE ARMY

RECEIVED
MAR 12 1946
RUP

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 02281 9

1. PLACE OF DEATH:

County Allegany
 City or town Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
 City or town Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Aspinwall
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Wm Brown Walker

3. (b) Social Security Number

214-07-1021

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M W married

8. (b) Name of husband or wife Emily Walker6. (c) If alive, give age 64 years7. Birth date of deceased (mo., day, yr.) aug 15 - 18768. AGE: Years Months Days If less than one day
69 7 16 hrs. min.9. Birthplace Chamberland-Alleg-Md
(Town, county, and state)10. Usual occupation rubber worker11. Industry or business Kelly Springfield Tire Co.12. Name James Walker13. Birthplace unknown ✓14. Maiden name Williamina Taylor15. Birthplace unknown ✓16. Informant Samuel WalkerAddress Smithsburg, Md.17. Burial Date thereof April 2 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory AlleganyLocation Smithsburg, Md18. Funeral director J. J. AdamsAddress Smithsburg19. 4-1 19 46 Mrs. Xaverly A. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1946 at 3:10 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 to Mar 31 1946and that I last saw him alive on Mar 29 1946Immediate cause of death Chronic myocarditis DURATION severalDue to Hypertension years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE 100M Lane M. D. or otherAddress East Huntington Date signed 4-7-46

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

APR 4 1946

BUREAU V.S.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution? 7 Hrs. 20 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County BedfordCity or town Hyndman
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William W. Warnke

3. (b) Social Security Number

169-07-5381

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteMarriedSarah Catherine Mason

8.(b) Name of husband or wife

6.(c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) December 13th, 18788. AGE: Years Months Days If less than one day
67 3 1 _____ hrs. _____ min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Retired Chemist11. Industry or business Claness Corp of America12. Name Unknown13. Birthplace "14. Maiden name Unknown15. Birthplace "16. Informant Mrs. Sarah WarnkeAddress Hyndman, Pa.17. Burial Date thereof March 17, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or XXXXX HyndmanLocation Hyndman, Pa.18. Funeral director Harvey H. ZeiglerAddress Hyndman, Pa.19. March 16 1946 Joseph P. Zeller, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/14 1946 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-13 1946 to 3-14 1946and that I last saw him alive on 3-14-46 1946Immediate cause of death Shock DURATION 9 hrs.Due to accident in auto

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-13-46Where did injury occur? Hyndman, Pa. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Little HighwayMeans of injury Wrote off road Injured at work? f23. SIGNATURE John A. Lupper, M.D. M. D. or otherAddress Hyndman, Pa. Date signed 3-15-46

MARGIN RESERVED FOR BINDING

VS A16

9.45

T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469

CERTIFICATE OF DEATH

02227

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 41 Maple St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Martha Elizabeth Partis

3. (b) Social Security Number

213-01-5941

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Oct. 10 - 1888

6. (c) If alive, give age years

8. AGE: Years Months Days It less than one day

57 5 16 hrs. min.9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)10. Usual occupation Buyer11. Industry or business Department Store12. Name Martha Elizabeth Partis13. Birthplace Frostburg, Md.14. Maiden name Johanna Schell15. Birthplace Frostburg, Md.16. Informant Mrs. Joseph StewartAddress 41 Maple St. Frostburg, Md.17. (Burial, cremation, or removal, Which?) Date thereof 3-29-1946
(month) (day) (year)Cemetery or crematory Allegany CemeteryLocation Frostburg, Md.18. Funeral director Janoff & SonsAddress Frostburg, Md.19. 3-29 46 Mrs. Nancy A. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1946 at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1943 to May 26 1946and that I last saw him alive on May 22 1946

Immediate cause of death

Carcinoma ofpancreas

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE 100M June 23, 1946 M. D. or otherAddress Frostburg, Md. Date signed 3-29-46

RECEIVED

APR 1 1946

BUREAU V.R.

Outside of
City limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02283

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH:

County Allegany
City or town Near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30. Years
Hospital, institution, or street address where death occurred:
Rural # 1.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Near Cumberland, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural # 1.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ida Blanche White

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Jesse W. White
6. (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) December 11, 1896
8. AGE: Years 49 Months 3 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Flintstone, Allegany, Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

12. Name Joseph McCoy
13. Birthplace Flintstone, Maryland
14. Maiden name Lucy Wharton
15. Birthplace Flintstone, Md.

16. Informant Jesse H. White
Address Locust Grove, Cumberland, Maryland
17. Burial Date thereof March 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Greenmont Cemetery
Location Cumberland, Maryland

18. Funeral director William H. Kight
Address Cumberland, Md.

19. March 25, 1946 J. P. Traublin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 19 46 at 6-30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1/46 19 to 19
and that I last saw him alive on 3/15/46 19

Immediate cause of death Carcinoma of Breasts
DURATION 1 yr.

Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A. Lopper M.D.
M. D. or other
Address Greenmont Date signed 3/23/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 3 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 02284

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

Allegany Hospital, Cumberland, MarylandHow long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County MineralCity or town Ridgeley
(If outside city or town limits, write RURAL and give nearest town)Street No. 12 Bridge St.
(If rural, give LOCATION)

2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

White, Mrs. Zena May

3. (b) Social Security Number

236-36-1583

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

White

Widowed Divorced

6. (b) Name of husband or wife Walter White

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 30th, 18978. AGE: Years Months Days If less than one day
48 6 2 _____ hrs. _____ min.9. Birthplace Parsons, Tucker Co., W. Va.
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own home12. Name John Snyder13. Birthplace Unknown14. Maiden name Arbela Smith15. Birthplace Parsons, W. Va.16. Informant Mrs. Hazel MessickAddress Wiley Ford, W. Va.17. Buried Date thereof March 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Roschill CemeteryLocation Cumberland, Md.18. Funeral director John J. H. HinesAddress Cumberland, Md.19. Mar. 5, 1946 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1946 10:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2-25-46 to 3-2-46 1946and that I last saw him alive on 3-2-46 1946Immediate cause of death ventricular fibrillation DURATION 5 minutesDue to embolism?Due to myocardialOther conditions uterus myometrium

(Include pregnancy within 3 months of death)

Major findings of operations uterus myometrium Date of op. 3-2-46

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. Hines M.D. M. D. or otherAddress Long Mac Date signed 3-2-46

RECEIVED

MAR 12 1946

BUREAU V. B.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02285

Reg. Dist. No.

4

1. PLACE OF DEATH:
 County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred:
422 Virginia Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 422 Virginia Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME
OSCAR T. WHITLOCK

3. (b) Social Security Number
214-10-5541

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. Ethelyn Whitlock
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) April 13, 1878
 8. AGE: Years 67 Months 10 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Capon Bridge, W. Va.
 (Town, county, and state)
 10. Usual occupation Bus Driver (Retired)
 11. Industry or business Potomac Edison Bus Co.
 12. Name Reeves Whitlock
 13. Birthplace Capon Bridge, W. Va.
 14. Maiden name Theresa
 15. Birthplace Capon Bridge, W. Va.

16. Informant Mrs. Ethelyn Whitlock
 Address 422 Virginia Ave. Cumberland, Md.
 17. Burial Date thereof March 6, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Cumberland, Maryland
 18. Funeral director William H. Kight
 Address Cumberland, Maryland

19. Mar 6 19 46 J. P. Franklin, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3, 1946 at 7 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15, 1946 to Mar 3, 1946
 and that I last saw him alive on Mar. 1, 1946

Immediate cause of death Myocarditis
 Due to Coronary Thrombosis - Sudden
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE Alay J. Jones
Cumberland M.D. or other 3/5/46
 Address _____ Date signed _____

RECEIVED

MAR 12 1946

BURY A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

02286

CERTIFICATE OF DEATH

Reg. Dist. No. 6

FILM No. I O 1 MAR 28 1946

1. PLACE OF DEATH:

County Allegany

City or town Lake
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany

City or town Lake
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Mamie Elmore Williams

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Geo. Williams

8. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April 27-1893

8. AGE: Years 52 Months 5-3 Days 10 If less than one day 15 hrs. _____ min.

9. Birthplace Sonabring - All. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Geo. F. Smith

13. Birthplace Md

14. Maiden name Ella Skinner

15. Birthplace Md

16. Informant Mr. Geo. Williams

Address Lake, Md

17. Burial Date thereof Mar 14, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Philis Cemetery

Location Westport - Md

18. Funeral director W. H. Fredrick

Address Piedmont, W. Va.

19. Mar 14 1946 Registrar Bayne
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 12 19 46 at 12:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19 42 to March 12 19 46
and that I last saw h. cr. alive on March 12 19 46

Immediate cause of death

Carcinoma of Rectum

DURATION

4 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE P. E. Berry M. D.

M. D. or other

Address Piedmont W. Va. Date signed 3/12/46

RECEIVED

MAR 16 1946

BUREAU V 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B)

02287

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County... Allegany

City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 91 mos.

Hospital, institution, or street address where death occurred:

506 Rose Hill Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany

City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 Rose Hill Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

Mary E Winter

3. (b) Social Security Number

None.

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

George Winter

7. Birth date of deceased (mo., day, yr.) Sept. 7 1854

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

91 6 3 hrs. min.

9. Birthplace... Cumberland Ind.

(Town, county, and state)

10. Usual occupation... Housework

11. Industry or business... at Home

12. Name... George Winter

13. Birthplace... Ind.

14. Maiden name... Sarah Combs

15. Birthplace... Ind.

16. Informant... Winter Family Dr. H.

Address... Cumberland

17. Burial, cremation, or removal, Which? Burial Date thereof... Mar. 12 46

(month) (day) (year)

Cemetery or crematory... Rose Hill Cem.

Location... Cumberland Ind.

18. Funeral director... Combs Stein Inc.

Address... Cumberland

19. Mar. 12 46 Joe P. Franklin M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 10 1946 at 9:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUL 1 1945 to March 11 1946

and that I last saw h.w. alive on March 10 1946

Immediate cause of death...

Chronic Myocarditis

Due to...

Due to...

Other conditions... Chr. Rheumatism

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... R. M. Waskowski

Address... 249 Green St

Date signed... 3-11-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 20 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

02288

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Brumfield
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

Allegheny Co InfirmaryHow long in hospital or institution? 10 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Brumfield
(If outside city or town limits, write RURAL and give nearest town)Street No. 441 Bond St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Bertha Young

3. (b) Social Security Number

none4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Thomas Young7. Birth date of deceased (mo., day, yr.) May 4 1875

8. AGE: Years Months Days If less than one day

70 10 16 hrs. min.9. Birthplace Brumfield Ind.
(Town, county, and state)10. Usual occupation Homemaker11. Industry or business at home12. Name Francis Messman13. Birthplace Germany14. Maiden name Elizabeth Doeber15. Birthplace Germany16. Informant Ans John T. WalshAddress Brumfield Ind.17. Burial, cremation, or removal. Which? burial Date thereof Mar 25 46
(month) (day) (year)Cemetery or crematory St Peter & Pauls CemLocation Brumfield18. Funeral director Louis Stein IncAddress Brumfield19. March 24 19 46 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 22 19 46 at 5:05 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3:18 to 3:22 19 46and that I last saw at alive on 3:20 19 46

Immediate cause of death

Carcinoma of pelvic organDue to Carcinoma of uterusDue to Carcinoma of uterus

Other conditions

(Include pregnancy within 4 months of death)

Major findings of operations NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D.Address Brumfield Date signed 3/22/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 3 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02289

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 86 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 49 W. Main St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Morittu Zeller

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 3 - 1859 6. (c) If alive, give age years

8. AGE: Years 86 Months 11 Days 23 (If less than one day) hrs. min.

9. Birthplace Zihlman, Allegany, Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Jules Workman

13. Birthplace Don't know

14. Maiden name Anna Troutman

15. Birthplace Don't know

18. Informant Mrs. Grace Kelley

Address 84 W. Main St. Frostburg, Md.

17. Burial Date thereof 3-29-1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Dager

Address Frostburg, Md.

19. 3-27 19 46 Mrs. Nancy V. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 46 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 19 45 to March 26 19 46 and that I last saw him pt. alive on March 25 19 46.

Immediate cause of death Arterio-sclerotic Corbis - vascular disease

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations X Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. Diehl M.D. M. D. or other

Address Frostburg, Md. Date signed 3/27/46

RECEIVED

MAR 30 1946

BUREAU